



Rep. Thaddeus Jones

## Adopted in House Comm. on Apr 02, 2024

10300HB5493ham002

LRB103 39189 RPS 71132 a

1 AMENDMENT TO HOUSE BILL 5493

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 5493 by replacing  
3 everything after the enacting clause with the following:

4 "Section 5. The State Employees Group Insurance Act of  
5 1971 is amended by changing Sections 6.7 and 6.11 as follows:

6 (5 ILCS 375/6.7)

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

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

12 (5 ILCS 375/6.11)

13 Sec. 6.11. Required health benefits; Illinois Insurance  
14 Code requirements. The program of health benefits shall  
15 provide the post-mastectomy care benefits required to be

1 covered by a policy of accident and health insurance under  
2 Section 356t of the Illinois Insurance Code. The program of  
3 health benefits shall provide the coverage required under  
4 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x,  
5 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10,  
6 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22,  
7 356z.25, 356z.26, 356z.29, 356z.30, ~~356z.30a~~, 356z.32,  
8 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,  
9 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59,  
10 356z.60, ~~and~~ 356z.61, ~~and~~ 356z.62, 356z.64, 356z.67, 356z.68,  
11 and 356z.70 of the Illinois Insurance Code. The program of  
12 health benefits must comply with Sections 155.22a, 155.37,  
13 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the  
14 Illinois Insurance Code. The program of health benefits shall  
15 provide the coverage required under Section 356m of the  
16 Illinois Insurance Code and, for the employees of the State  
17 Employee Group Insurance Program only, the coverage as also  
18 provided in Section 6.11B of this Act. The Department of  
19 Insurance shall enforce the requirements of this Section with  
20 respect to Sections 370c and 370c.1 of the Illinois Insurance  
21 Code; all other requirements of this Section shall be enforced  
22 by the Department of Central Management Services.

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

1 Administrative Rules; any purported rule not so adopted, for  
2 whatever reason, is unauthorized.

3 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
4 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.  
5 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-768,  
6 eff. 1-1-24; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;  
7 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.  
8 1-1-23; 102-1117, eff. 1-13-23; 103-8, eff. 1-1-24; 103-84,  
9 eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24;  
10 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff.  
11 8-11-23; revised 8-29-23.)

12 Section 10. The Counties Code is amended by changing  
13 Sections 5-1069.3 and 5-1069.5 as follows:

14 (55 ILCS 5/5-1069.3)

15 Sec. 5-1069.3. Required health benefits. If a county,  
16 including a home rule county, is a self-insurer for purposes  
17 of providing health insurance coverage for its employees, the  
18 coverage shall include coverage for the post-mastectomy care  
19 benefits required to be covered by a policy of accident and  
20 health insurance under Section 356t and the coverage required  
21 under Sections 356g, 356g.5, 356g.5-1, 356q, 356u, 356w, 356x,  
22 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11,  
23 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26,  
24 356z.29, 356z.30, ~~356z.30a~~, 356z.32, 356z.33, 356z.36,

1 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51,  
2 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, ~~and~~  
3 356z.61, ~~and~~ 356z.62, 356z.64, 356z.67, 356z.68, and 356z.70  
4 of the Illinois Insurance Code. The coverage shall comply with  
5 Sections 155.22a, 355b, 356z.19, and 370c of the Illinois  
6 Insurance Code. The Department of Insurance shall enforce the  
7 requirements of this Section. The requirement that health  
8 benefits be covered as provided in this Section is an  
9 exclusive power and function of the State and is a denial and  
10 limitation under Article VII, Section 6, subsection (h) of the  
11 Illinois Constitution. A home rule county to which this  
12 Section applies must comply with every provision of this  
13 Section.

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

20 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
21 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
22 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,  
23 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;  
24 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.  
25 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,  
26 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;

1 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; revised  
2 8-29-23.)

3 (55 ILCS 5/5-1069.5)

4 Sec. 5-1069.5. Access to obstetrical and gynecological  
5 care ~~Woman's health care provider~~. All counties, including  
6 home rule counties, are subject to the provisions of Section  
7 356r of the Illinois Insurance Code. The requirement under  
8 this Section that health care benefits provided by counties  
9 comply with Section 356r of the Illinois Insurance Code is an  
10 exclusive power and function of the State and is a denial and  
11 limitation of home rule county powers under Article VII,  
12 Section 6, subsection (h) of the Illinois Constitution.  
13 (Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

14 Section 15. The Illinois Municipal Code is amended by  
15 changing Sections 10-4-2.3 and 10-4-2.5 as follows:

16 (65 ILCS 5/10-4-2.3)

17 Sec. 10-4-2.3. Required health benefits. If a  
18 municipality, including a home rule municipality, is a  
19 self-insurer for purposes of providing health insurance  
20 coverage for its employees, the coverage shall include  
21 coverage for the post-mastectomy care benefits required to be  
22 covered by a policy of accident and health insurance under  
23 Section 356t and the coverage required under Sections 356g,

1 356g.5, 356g.5-1, 356q, 356u, 356w, 356x, 356z.4, 356z.4a,  
2 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,  
3 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,  
4 ~~356z.30a,~~ 356z.32, 356z.33, 356z.36, 356z.40, 356z.41,  
5 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54,  
6 356z.56, 356z.57, 356z.59, 356z.60, ~~and~~ 356z.61, ~~and~~ 356z.62,  
7 356z.64, 356z.67, 356z.68, and 356z.70 of the Illinois  
8 Insurance Code. The coverage shall comply with Sections  
9 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance  
10 Code. The Department of Insurance shall enforce the  
11 requirements of this Section. The requirement that health  
12 benefits be covered as provided in this is an exclusive power  
13 and function of the State and is a denial and limitation under  
14 Article VII, Section 6, subsection (h) of the Illinois  
15 Constitution. A home rule municipality to which this Section  
16 applies must comply with every provision of this Section.

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

23 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
24 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
25 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,  
26 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;

1 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.  
2 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,  
3 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;  
4 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; revised  
5 8-29-23.)

6 (65 ILCS 5/10-4-2.5)

7 Sec. 10-4-2.5. Access to obstetrical and gynecological  
8 care ~~Woman's health care provider~~. The corporate authorities  
9 of all municipalities are subject to the provisions of Section  
10 356r of the Illinois Insurance Code. The requirement under  
11 this Section that health care benefits provided by  
12 municipalities comply with Section 356r of the Illinois  
13 Insurance Code is an exclusive power and function of the State  
14 and is a denial and limitation of home rule municipality  
15 powers under Article VII, Section 6, subsection (h) of the  
16 Illinois Constitution.

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

18 Section 20. The School Code is amended by changing  
19 Sections 10-22.3d and 10-22.3f as follows:

20 (105 ILCS 5/10-22.3d)

21 Sec. 10-22.3d. Access to obstetrical and gynecological  
22 care ~~Woman's health care provider~~. Insurance protection and  
23 benefits for employees are subject to the provisions of

1 Section 356r of the Illinois Insurance Code.

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

3 (105 ILCS 5/10-22.3f)

4 Sec. 10-22.3f. Required health benefits. Insurance  
5 protection and benefits for employees shall provide the  
6 post-mastectomy care benefits required to be covered by a  
7 policy of accident and health insurance under Section 356t and  
8 the coverage required under Sections 356g, 356g.5, 356g.5-1,  
9 356q, 356u, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8,  
10 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,  
11 356z.25, 356z.26, 356z.29, 356z.30, ~~356z.30a~~, 356z.32,  
12 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,  
13 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,  
14 ~~and~~ 356z.61, ~~and~~ 356z.62, 356z.64, 356z.67, 356z.68, and  
15 356z.70 of the Illinois Insurance Code. Insurance policies  
16 shall comply with Section 356z.19 of the Illinois Insurance  
17 Code. The coverage shall comply with Sections 155.22a, 355b,  
18 and 370c of the Illinois Insurance Code. The Department of  
19 Insurance shall enforce the requirements of this Section.

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



1 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
2 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.  
3 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804,  
4 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;  
5 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff.  
6 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420,  
7 eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23;  
8 103-551, eff. 8-11-23; revised 8-29-23.)

9 Section 25. The Illinois Insurance Code is amended by  
10 changing Sections 4, 352, 352b, 356a, 356b, 356d, 356e, 356f,  
11 356K, 356L, 356r, 356s, 356z.3, 356z.33, 367a, 370e, 370i,  
12 408, 412, and 531.03 as follows:

13 (215 ILCS 5/4) (from Ch. 73, par. 616)

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

16 Class 1. Life, Accident and Health.

17 (a) Life. Insurance on the lives of persons and every  
18 insurance appertaining thereto or connected therewith and  
19 granting, purchasing or disposing of annuities. Policies of  
20 life or endowment insurance or annuity contracts or contracts  
21 supplemental thereto which contain provisions for additional  
22 benefits in case of death by accidental means and provisions  
23 operating to safeguard such policies or contracts against  
24 lapse, to give a special surrender value, or special benefit,

1 or an annuity, in the event, that the insured or annuitant  
2 shall become a person with a total and permanent disability as  
3 defined by the policy or contract, or which contain benefits  
4 providing acceleration of life or endowment or annuity  
5 benefits in advance of the time they would otherwise be  
6 payable, as an indemnity for long term care which is certified  
7 or ordered by a physician, including but not limited to,  
8 professional nursing care, medical care expenses, custodial  
9 nursing care, non-nursing custodial care provided in a nursing  
10 home or at a residence of the insured, or which contain  
11 benefits providing acceleration of life or endowment or  
12 annuity benefits in advance of the time they would otherwise  
13 be payable, at any time during the insured's lifetime, as an  
14 indemnity for a terminal illness shall be deemed to be  
15 policies of life or endowment insurance or annuity contracts  
16 within the intent of this clause.

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

25 "Covered condition", as used in this clause, means: heart  
26 attack, stroke, coronary artery surgery, life-threatening life

1 ~~threatening~~ cancer, renal failure, Alzheimer's disease,  
2 paraplegia, major organ transplantation, total and permanent  
3 disability, and any other medical condition that the  
4 Department may approve for any particular filing.

5 The Director may issue rules that specify prohibited  
6 policy provisions, not otherwise specifically prohibited by  
7 law, which in the opinion of the Director are unjust, unfair,  
8 or unfairly discriminatory to the policyholder, any person  
9 insured under the policy, or beneficiary.

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

1 when the arrangement and organization meet all of the  
2 following criteria:

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

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

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

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

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

22 (vi) the organization or a predecessor organization  
23 has been in existence at all times since December 31,  
24 1999, and medical expenses of its members have been shared  
25 continuously and without interruption since at least  
26 December 31, 1999;

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

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

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

21           (ix) any membership card or similar document issued by  
22 the organization and any written communication sent by the  
23 organization to a hospital, physician, or other health  
24 care provider shall include a statement that the  
25 organization does not issue health insurance and that the  
26 member or participant is personally liable for payment of

1 his or her medical bills;

2 (x) the organization provides to a participant, within  
3 30 days after the participant joins, a complete set of its  
4 rules for the sharing of medical expenses, appeals of  
5 decisions made by the organization, and the filing of  
6 complaints;

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

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

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

1 Act do not apply to:

2 (i) retainer contracts made by attorneys at law with  
3 individual clients with fees based on estimates of the  
4 nature and amount of services to be provided to the  
5 specific client, and similar contracts made with a group  
6 of clients involved in the same or closely related legal  
7 matters;

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

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

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

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

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

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

4           (viii) any collectively bargained plan for legal  
5 services between a labor union and an employer negotiated  
6 pursuant to Section 302 of the Labor Management Relations  
7 Act as now or hereafter amended, under which plan legal  
8 services will be provided for employees of the employer  
9 whether or not payments for such services are funded to or  
10 through an insurance company.

11           Class 2. Casualty, Fidelity and Surety.

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

21           (b) Vehicle. Insurance against any loss or liability  
22 resulting from or incident to the ownership, maintenance or  
23 use of any vehicle (motor or otherwise), draft animal or  
24 aircraft. Any policy insuring against any loss or liability on  
25 account of the bodily injury or death of any person may contain  
26 a provision for payment of disability benefits to injured



1 persons and death benefits to dependents, beneficiaries or  
2 personal representatives of persons who are killed, including  
3 the named insured, irrespective of legal liability of the  
4 insured, if the injury or death for which benefits are  
5 provided is caused by accident and sustained while in or upon  
6 or while entering into or alighting from or through being  
7 struck by a vehicle (motor or otherwise), draft animal or  
8 aircraft, and such provision shall not be deemed to be  
9 accident insurance.

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

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

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

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

25 (g) Fidelity and surety. Become surety or guarantor for  
26 any person, copartnership or corporation in any position or

1 place of trust or as custodian of money or property, public or  
2 private; or, becoming a surety or guarantor for the  
3 performance of any person, copartnership or corporation of any  
4 lawful obligation, undertaking, agreement or contract of any  
5 kind, except contracts or policies of insurance; and  
6 underwriting blanket bonds. Such obligations shall be known  
7 and treated as suretyship obligations and such business shall  
8 be known as surety business.

9 (h) Miscellaneous. Insurance against loss or damage to  
10 property and any liability of the insured caused by accidents  
11 to boilers, pipes, pressure containers, machinery and  
12 apparatus of any kind and any apparatus connected thereto, or  
13 used for creating, transmitting or applying power, light,  
14 heat, steam or refrigeration, making inspection of and issuing  
15 certificates of inspection upon elevators, boilers, machinery  
16 and apparatus of any kind and all mechanical apparatus and  
17 appliances appertaining thereto; insurance against loss or  
18 damage by water entering through leaks or openings in  
19 buildings, or from the breakage or leakage of a sprinkler,  
20 pumps, water pipes, plumbing and all tanks, apparatus,  
21 conduits and containers designed to bring water into buildings  
22 or for its storage or utilization therein, or caused by the  
23 falling of a tank, tank platform or supports, or against loss  
24 or damage from any cause (other than causes specifically  
25 enumerated under Class 3 of this Section) to such sprinkler,  
26 pumps, water pipes, plumbing, tanks, apparatus, conduits or

1 containers; insurance against loss or damage which may result  
2 from the failure of debtors to pay their obligations to the  
3 insured; and insurance of the payment of money for personal  
4 services under contracts of hiring.

5 (i) Other casualty risks. Insurance against any other  
6 casualty risk not otherwise specified under Classes 1 or 3,  
7 which may lawfully be the subject of insurance and may  
8 properly be classified under Class 2.

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

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

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

21 Class 3. Fire and Marine, etc.

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

24 (b) Elements. Insurance against loss or damage by  
25 earthquake, windstorms, cyclone, tornado, tempests, hail,  
26 frost, snow, ice, sleet, flood, rain, drought or other weather

1 or climatic conditions including excess or deficiency of  
2 moisture, rising of the waters of the ocean or its  
3 tributaries.

4 (c) War, riot and explosion. Insurance against loss or  
5 damage by bombardment, invasion, insurrection, riot, strikes,  
6 civil war or commotion, military or usurped power, or  
7 explosion (other than explosion of steam boilers and the  
8 breaking of fly wheels on premises owned, controlled, managed,  
9 or maintained by the insured).

10 (d) Marine and transportation. Insurance against loss or  
11 damage to vessels, craft, aircraft, vehicles of every kind,  
12 (excluding vehicles operating under their own power or while  
13 in storage not incidental to transportation) as well as all  
14 goods, freights, cargoes, merchandise, effects, disbursements,  
15 profits, moneys, bullion, precious stones, securities, choses  
16 in action, evidences of debt, valuable papers, bottomry and  
17 respondentia interests and all other kinds of property and  
18 interests therein, in respect to, appertaining to or in  
19 connection with any or all risks or perils of navigation,  
20 transit, or transportation, including war risks, on or under  
21 any seas or other waters, on land or in the air, or while being  
22 assembled, packed, crated, baled, compressed or similarly  
23 prepared for shipment or while awaiting the same or during any  
24 delays, storage, transshipment, or reshipment incident  
25 thereto, including marine builder's risks and all personal  
26 property floater risks; and for loss or damage to persons or

1 property in connection with or appertaining to marine, inland  
2 marine, transit or transportation insurance, including  
3 liability for loss of or damage to either arising out of or in  
4 connection with the construction, repair, operation,  
5 maintenance, or use of the subject matter of such insurance,  
6 (but not including life insurance or surety bonds); but,  
7 except as herein specified, shall not mean insurances against  
8 loss by reason of bodily injury to the person; and insurance  
9 against loss or damage to precious stones, jewels, jewelry,  
10 gold, silver and other precious metals whether used in  
11 business or trade or otherwise and whether the same be in  
12 course of transportation or otherwise, which shall include  
13 jewelers' block insurance; and insurance against loss or  
14 damage to bridges, tunnels and other instrumentalities of  
15 transportation and communication (excluding buildings, their  
16 furniture and furnishings, fixed contents and supplies held in  
17 storage) unless fire, tornado, sprinkler leakage, hail,  
18 explosion, earthquake, riot and civil commotion are the only  
19 hazards to be covered; and to piers, wharves, docks and slips,  
20 excluding the risks of fire, tornado, sprinkler leakage, hail,  
21 explosion, earthquake, riot and civil commotion; and to other  
22 aids to navigation and transportation, including dry docks and  
23 marine railways, against all risk.

24 (e) Vehicle. Insurance against loss or liability resulting  
25 from or incident to the ownership, maintenance or use of any  
26 vehicle (motor or otherwise), draft animal or aircraft,

1 excluding the liability of the insured for the death, injury  
2 or disability of another person.

3 (f) Property damage, sprinkler leakage and crop. Insurance  
4 against the liability of the insured for loss or damage to  
5 another person's property or property interests from any cause  
6 enumerated in this class; insurance against loss or damage by  
7 water entering through leaks or openings in buildings, or from  
8 the breakage or leakage of a sprinkler, pumps, water pipes,  
9 plumbing and all tanks, apparatus, conduits and containers  
10 designed to bring water into buildings or for its storage or  
11 utilization therein, or caused by the falling of a tank, tank  
12 platform or supports or against loss or damage from any cause  
13 to such sprinklers, pumps, water pipes, plumbing, tanks,  
14 apparatus, conduits or containers; insurance against loss or  
15 damage from insects, diseases or other causes to trees, crops  
16 or other products of the soil.

17 (g) Other fire and marine risks. Insurance against any  
18 other property risk not otherwise specified under Classes 1 or  
19 2, which may lawfully be the subject of insurance and may  
20 properly be classified under Class 3.

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

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

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

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

6 Sec. 352. Scope of Article.

7 (a) Except as provided in subsections (b), (c), (d), ~~and~~  
8 (e), and (g), this Article shall apply to all companies  
9 transacting in this State the kinds of business enumerated in  
10 clause (b) of Class 1 and clause (a) of Class 2 of Section 4  
11 and to all policies, contracts, and certificates of insurance  
12 issued in connection therewith that are not otherwise excluded  
13 under Article VII of this Code. Nothing in this Article shall  
14 apply to, or in any way affect policies or contracts described  
15 in clause (a) of Class 1 of Section 4; however, this Article  
16 shall apply to policies and contracts which contain benefits  
17 providing reimbursement for the expenses of long term health  
18 care which are certified or ordered by a physician including  
19 but not limited to professional nursing care, custodial  
20 nursing care, and non-nursing custodial care provided in a  
21 nursing home or at a residence of the insured.

22 (b) (Blank).

23 (c) A policy issued and delivered in this State that  
24 provides coverage under that policy for certificate holders  
25 who are neither residents of nor employed in this State does

1 not need to provide to those nonresident certificate holders  
2 who are not employed in this State the coverages or services  
3 mandated by this Article.

4 (d) Stop-loss insurance, as defined in clause (b) of Class  
5 1 or clause (a) of Class 2 of Section 4, is exempt from all  
6 Sections of this Article, except this Section and Sections  
7 353a, 354, 357.30, and 370. ~~For purposes of this exemption,~~  
8 ~~stop loss insurance is further defined as follows:~~

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

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

16 (e) A policy issued or delivered in this State to the  
17 Department of Healthcare and Family Services (formerly  
18 Illinois Department of Public Aid) and providing coverage,  
19 under clause (b) of Class 1 or clause (a) of Class 2 as  
20 described in Section 4, to persons who are enrolled under  
21 Article V of the Illinois Public Aid Code or under the  
22 Children's Health Insurance Program Act is exempt from all  
23 restrictions, limitations, standards, rules, or regulations  
24 respecting benefits imposed by or under authority of this  
25 Code, except those specified by subsection (1) of Section 143,  
26 Section 370c, and Section 370c.1. Nothing in this subsection,



1 however, affects the total medical services available to  
2 persons eligible for medical assistance under the Illinois  
3 Public Aid Code.

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

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

9 (1) any policy or contract of reinsurance; or

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

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

21 (215 ILCS 5/352b)

22 Sec. 352b. Excepted benefits exempted ~~Policy of individual~~  
23 ~~or group accident and health insurance.~~

24 (a) Unless specified otherwise and when used in context of  
25 accident and health insurance policy benefits, coverage,

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

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

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

21 (215 ILCS 5/356a) (from Ch. 73, par. 968a)

22 Sec. 356a. Form of policy.

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

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

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

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

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

24           (e) the exceptions and reductions of indemnity are set  
25 forth in the policy and, except those which are set forth  
26 in Sections 357.1 through 357.30 of this act, are printed,

1 at the insurer's option, either included with the benefit  
2 provision to which they apply, or under an appropriate  
3 caption such as "EXCEPTIONS", or "EXCEPTIONS AND  
4 REDUCTIONS", provided that if an exception or reduction  
5 specifically applies only to a particular benefit of the  
6 policy, a statement of such exception or reduction shall  
7 be included with the benefit provision to which it  
8 applies; and

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

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

19 (2) If any policy is issued by an insurer domiciled in this  
20 state for delivery to a person residing in another state, and  
21 if the official having responsibility for the administration  
22 of the insurance laws of such other state shall have advised  
23 the Director that any such policy is not subject to approval or  
24 disapproval by such official, the Director may by ruling  
25 require that such policy meet the standards set forth in  
26 subsection (1) of this section and in Sections 357.1 through

1 357.30.

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

3 (215 ILCS 5/356b) (from Ch. 73, par. 968b)

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

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

16 (c) For purposes of subsection (b), "dependent on other  
17 care providers" is defined as requiring a Community Integrated  
18 Living Arrangement, group home, supervised apartment, or other  
19 residential services licensed or certified by the Department  
20 of Human Services (as successor to the Department of Mental  
21 Health and Developmental Disabilities), the Department of  
22 Public Health, or the Department of Healthcare and Family  
23 Services (formerly Department of Public Aid).

24 (d) The insurer may inquire of the policyholder 2 months  
25 prior to attainment by a dependent of the limiting age set

1     forth in the policy, or at any reasonable time thereafter,  
2     whether such dependent is in fact a person who has a disability  
3     and is dependent and, in the absence of proof submitted within  
4     60 days of such inquiry that such dependent is a person who has  
5     a disability and is dependent may terminate coverage of such  
6     person at or after attainment of the limiting age. In the  
7     absence of such inquiry, coverage of any person who has a  
8     disability and is dependent shall continue through the term of  
9     such policy or any extension or renewal thereof.

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

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

14       (215 ILCS 5/356d) (from Ch. 73, par. 968d)

15       Sec. 356d. Conversion privileges for insured former  
16     spouses. (1) No individual policy of accident and health  
17     insurance providing coverage of hospital and/or medical  
18     expense on either an expense incurred basis or other than an  
19     expense incurred basis, which in addition to covering the  
20     insured also provides coverage to the spouse of the insured  
21     shall contain a provision for termination of coverage for a  
22     spouse covered under the policy solely as a result of a break  
23     in the marital relationship except by reason of an entry of a  
24     valid judgment of dissolution of marriage between the parties.

25       (2) Every policy which contains a provision for

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

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

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

19 (215 ILCS 5/356e) (from Ch. 73, par. 968e)

20 Sec. 356e. Victims of certain offenses.

21 (1) No individual policy of accident and health insurance,  
22 which provides benefits for hospital or medical expenses based  
23 upon the actual expenses incurred, delivered or issued for  
24 delivery to any person in this State shall contain any  
25 specific exception to coverage which would preclude the

1 payment under that policy of actual expenses incurred in the  
2 examination and testing of a victim of an offense defined in  
3 Sections 11-1.20 through 11-1.60 or 12-13 through 12-16 of the  
4 Criminal Code of 1961 or the Criminal Code of 2012, or an  
5 attempt to commit such offense to establish that sexual  
6 contact did occur or did not occur, and to establish the  
7 presence or absence of sexually transmitted disease or  
8 infection, and examination and treatment of injuries and  
9 trauma sustained by a victim of such offense arising out of the  
10 offense. Every policy of accident and health insurance which  
11 specifically provides benefits for routine physical  
12 examinations shall provide full coverage for expenses incurred  
13 in the examination and testing of a victim of an offense  
14 defined in Sections 11-1.20 through 11-1.60 or 12-13 through  
15 12-16 of the Criminal Code of 1961 or the Criminal Code of  
16 2012, or an attempt to commit such offense as set forth in this  
17 Section. This Section shall not apply to a policy which covers  
18 hospital and medical expenses for specified illnesses or  
19 injuries only.

20 (2) For purposes of enabling the recovery of State funds,  
21 any insurance carrier subject to this Section shall upon  
22 reasonable demand by the Department of Public Health disclose  
23 the names and identities of its insureds entitled to benefits  
24 under this provision to the Department of Public Health  
25 whenever the Department of Public Health has determined that  
26 it has paid, or is about to pay, hospital or medical expenses



1 for which an insurance carrier is liable under this Section.  
2 All information received by the Department of Public Health  
3 under this provision shall be held on a confidential basis and  
4 shall not be subject to subpoena and shall not be made public  
5 by the Department of Public Health or used for any purpose  
6 other than that authorized by this Section.

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

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

16 (215 ILCS 5/356f) (from Ch. 73, par. 968f)

17 Sec. 356f. No individual policy of accident or health  
18 insurance or any renewal thereof shall be denied or cancelled  
19 by the insurer, nor shall any such policy contain any  
20 exception or exclusion of benefits, solely because the mother  
21 of the insured has taken diethylstilbestrol, commonly referred  
22 to as DES.

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

24 (215 ILCS 5/356K) (from Ch. 73, par. 968K)

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

25   (Source: P.A. 87-218.)

1 (215 ILCS 5/356L) (from Ch. 73, par. 968L)

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

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

12 (215 ILCS 5/356r)

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

15 (a) An individual or group policy of accident and health  
16 insurance or a managed care plan amended, delivered, issued,  
17 or renewed in this State must not require authorization or  
18 referral by the plan, issuer, or any person, including a  
19 primary care provider, for any covered individual who seeks  
20 coverage for obstetrical or gynecological care provided by any  
21 licensed or certified participating health care professional  
22 who specializes in obstetrics or gynecology. after November  
23 ~~14, 1996 that requires an insured or enrollee to designate an~~  
24 ~~individual to coordinate care or to control access to health~~  
25 ~~care services shall also permit a female insured or enrollee~~

1 ~~to designate a participating woman's principal health care~~  
2 ~~provider, and the insurer or managed care plan shall provide~~  
3 ~~the following written notice to all female insureds or~~  
4 ~~enrollees no later than 120 days after the effective date of~~  
5 ~~this amendatory Act of 1998; to all new enrollees at the time~~  
6 ~~of enrollment; and thereafter to all existing enrollees at~~  
7 ~~least annually, as a part of a regular publication or~~  
8 ~~informational mailing:~~

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

10 ~~YOUR RIGHT TO SELECT A WOMAN'S PRINCIPAL~~  
11 ~~HEALTH CARE PROVIDER.~~

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

24 ~~Your woman's principal health care provider must be a~~  
25 ~~part of your plan. You may get the list of participating~~  
26 ~~obstetricians, gynecologists, and family practice~~

1 ~~specialists from your employer's employee benefits~~  
2 ~~coordinator, or for your own copy of the current list, you~~  
3 ~~may call [insert plan's toll free number]. The list will~~  
4 ~~be sent to you within 10 days after your call. To designate~~  
5 ~~a woman's principal health care provider from the list,~~  
6 ~~call [insert plan's toll free number] and tell our staff~~  
7 ~~the name of the physician you have selected.".~~

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

10 ~~"Your plan requires that your primary care physician~~  
11 ~~and your woman's principal health care provider have a~~  
12 ~~referral arrangement with one another. If the woman's~~  
13 ~~principal health care provider that you select does not~~  
14 ~~have a referral arrangement with your primary care~~  
15 ~~physician, you will have to select a new primary care~~  
16 ~~physician who has a referral arrangement with your woman's~~  
17 ~~principal health care provider or you may select a woman's~~  
18 ~~principal health care provider who has a referral~~  
19 ~~arrangement with your primary care physician. The list of~~  
20 ~~woman's principal health care providers will also have the~~  
21 ~~names of the primary care physicians and their referral~~  
22 ~~arrangements.".~~

23 ~~No later than 120 days after the effective date of this~~  
24 ~~amendatory Act of 1998, the insurer or managed care plan shall~~  
25 ~~provide each employer who has a policy of insurance or a~~  
26 ~~managed care plan with the insurer or managed care plan with a~~

1 ~~list of physicians licensed to practice medicine in all its~~  
2 ~~branches specializing in obstetrics or gynecology or~~  
3 ~~specializing in family practice who have contracted with the~~  
4 ~~plan. At the time of enrollment and thereafter within 10 days~~  
5 ~~after a request by an insured or enrollee, the insurer or~~  
6 ~~managed care plan also shall provide this list directly to the~~  
7 ~~insured or enrollee. The list shall include each physician's~~  
8 ~~address, telephone number, and specialty. No insurer or plan~~  
9 ~~formal or informal policy may restrict a female insured's or~~  
10 ~~enrollee's right to designate a woman's principal health care~~  
11 ~~provider, except as set forth in subsection (a-5). If the~~  
12 ~~female enrollee is an enrollee of a managed care plan under~~  
13 ~~contract with the Department of Healthcare and Family~~  
14 ~~Services, the physician chosen by the enrollee as her woman's~~  
15 ~~principal health care provider must be a Medicaid enrolled~~  
16 ~~provider. This requirement does not require a female insured~~  
17 ~~or enrollee to make a selection of a woman's principal health~~  
18 ~~care provider. The female insured or enrollee may designate a~~  
19 ~~physician licensed to practice medicine in all its branches~~  
20 ~~specializing in family practice as her woman's principal~~  
21 ~~health care provider.~~

22 (a-5) If a policy, contract, or certificate requires or  
23 allows a covered individual to designate a primary care  
24 provider and provides coverage for any obstetrical or  
25 gynecological care, the insurer shall provide the notice  
26 required under 45 CFR 147.138(a)(4) and 149.310(a)(4) in all

1 circumstances required under that provision. ~~The insured or~~  
2 ~~enrollee may be required by the insurer or managed care plan to~~  
3 ~~select a woman's principal health care provider who has a~~  
4 ~~referral arrangement with the insured's or enrollee's~~  
5 ~~individual who coordinates care or controls access to health~~  
6 ~~care services if such referral arrangement exists or to select~~  
7 ~~a new individual to coordinate care or to control access to~~  
8 ~~health care services who has a referral arrangement with the~~  
9 ~~woman's principal health care provider chosen by the insured~~  
10 ~~or enrollee, if such referral arrangement exists. If an~~  
11 ~~insurer or a managed care plan requires an insured or enrollee~~  
12 ~~to select a new physician under this subsection (a-5), the~~  
13 ~~insurer or managed care plan must provide the insured or~~  
14 ~~enrollee with both options to select a new physician provided~~  
15 ~~in this subsection (a-5).~~

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

22 (a-6) The requirements of this Section shall be construed  
23 in a manner consistent with the requirements for access to and  
24 notice of obstetrical and gynecological care in 45 CFR 147.138  
25 and 45 CFR 149.310. ~~If an insurer or managed care plan~~  
26 ~~exercises the option in subsection (a-5), the list to be~~

1 ~~provided under subsection (a) shall identify the referral~~  
2 ~~arrangements that exist between the individual who coordinates~~  
3 ~~care or controls access to health care services and the~~  
4 ~~woman's principal health care provider in order to assist the~~  
5 ~~female insured or enrollee to make a selection within the~~  
6 ~~insurer's or managed care plan's requirement.~~

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

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

26 ~~(1) "Woman's principal health care provider" means a~~



1 ~~physician licensed to practice medicine in all of its~~  
2 ~~branches specializing in obstetrics or gynecology or~~  
3 ~~specializing in family practice.~~

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

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

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

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

22 ~~(4) "Participating provider" means a physician who has~~  
23 ~~contracted with an insurer or managed care plan to provide~~  
24 ~~services to insureds or enrollees as defined by the~~  
25 ~~contract.~~

26 (d) Nothing in this Section shall be construed to preclude

1 a health insurance issuer from requiring that a participating  
2 obstetrical or gynecological health care professional notify  
3 the covered individual's primary care physician or the issuer  
4 of treatment decisions or update centralized medical records.

5 ~~The original provisions of this Section became law on July 17,~~  
6 ~~1996 and took effect November 14, 1996, which is 120 days after~~  
7 ~~becoming law.~~

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

9 (215 ILCS 5/356s)

10 Sec. 356s. Post-parturition care. An individual or group  
11 policy of accident and health insurance that provides  
12 maternity coverage and is amended, delivered, issued, or  
13 renewed after the effective date of this amendatory Act of  
14 1996 shall provide coverage for the following:

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

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

21 Coverage may be limited to a ~~A~~ shorter length of ~~hospital~~  
22 inpatient care stay ~~stay~~ for services related to maternity and  
23 newborn care ~~may be provided~~ if the attending physician  
24 licensed to practice medicine in all of its branches  
25 determines, in accordance with the protocols and guidelines

1 developed by the American College of Obstetricians and  
2 Gynecologists or the American Academy of Pediatrics, that the  
3 mother and the newborn meet the appropriate guidelines for  
4 that length of stay based upon evaluation of the mother and  
5 newborn and the coverage and availability of a post-discharge  
6 physician office visit or in-home nurse visit to verify the  
7 condition of the infant in the first 48 hours after discharge.  
8 (Source: P.A. 89-513, eff. 9-15-96; 90-14, eff. 7-1-97.)

9 (215 ILCS 5/356z.3)

10 Sec. 356z.3. Disclosure of limited benefit. An insurer  
11 that issues, delivers, amends, or renews an individual or  
12 group policy of accident and health insurance in this State  
13 after the effective date of this amendatory Act of the 92nd  
14 General Assembly and arranges, contracts with, or administers  
15 contracts with a provider whereby beneficiaries are provided  
16 an incentive to use the services of such provider must include  
17 the following disclosure on its contracts and evidences of  
18 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN  
19 NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO PAY  
20 MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN  
21 NON-EMERGENCY SITUATIONS. Except in limited situations  
22 governed by the federal No Surprises Act or Section 356z.3a of  
23 the Illinois Insurance Code (215 ILCS 5/356z.3a),  
24 non-participating providers furnishing non-emergency services  
25 may bill members for any amount up to the billed charge after

1 the plan has paid its portion of the bill. If you elect to use  
2 a non-participating provider, plan benefit payments will be  
3 determined according to your policy's fee schedule, usual and  
4 customary charge (which is determined by comparing charges for  
5 similar services adjusted to the geographical area where the  
6 services are performed), or other method as defined by the  
7 policy. Participating providers have agreed to ONLY bill  
8 members the cost-sharing amounts. You should be aware that  
9 ~~when you elect to utilize the services of a non-participating~~  
10 ~~provider for a covered service in non-emergency situations,~~  
11 ~~benefit payments to such non-participating provider are not~~  
12 ~~based upon the amount billed. The basis of your benefit~~  
13 ~~payment will be determined according to your policy's fee~~  
14 ~~schedule, usual and customary charge (which is determined by~~  
15 ~~comparing charges for similar services adjusted to the~~  
16 ~~geographical area where the services are performed), or other~~  
17 ~~method as defined by the policy. YOU CAN EXPECT TO PAY MORE~~  
18 ~~THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE~~  
19 ~~PLAN HAS PAID ITS REQUIRED PORTION. Non participating~~  
20 ~~providers may bill members for any amount up to the billed~~  
21 ~~charge after the plan has paid its portion of the bill, except~~  
22 ~~as provided in Section 356z.3a of the Illinois Insurance Code~~  
23 ~~for covered services received at a participating health care~~  
24 ~~facility from a nonparticipating provider that are: (a)~~  
25 ~~ancillary services, (b) items or services furnished as a~~  
26 ~~result of unforeseen, urgent medical needs that arise at the~~

1 ~~time the item or service is furnished, or (c) items or services~~  
2 ~~received when the facility or the non-participating provider~~  
3 ~~fails to satisfy the notice and consent criteria specified~~  
4 ~~under Section 356z.3a. Participating providers have agreed to~~  
5 ~~accept discounted payments for services with no additional~~  
6 ~~billing to the member other than co insurance and deductible~~  
7 ~~amounts.~~ You may obtain further information about the  
8 participating status of professional providers and information  
9 on out-of-pocket expenses by calling the toll-free ~~toll-free~~  
10 telephone number on your identification card."

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

12 (215 ILCS 5/356z.33)

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

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

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

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

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

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

10           (b) An insurer that provides coverage for medically  
11 necessary epinephrine injectors shall limit the total amount  
12 that an insured is required to pay for a twin-pack of medically  
13 necessary epinephrine injectors at an amount not to exceed  
14 \$60, regardless of the type of epinephrine injector; except  
15 that this provision does not apply to the extent such coverage  
16 would disqualify a high-deductible health plan from  
17 eligibility for a health savings account pursuant to Section  
18 223 of the Internal Revenue Code (26 U.S.C. 223).

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

22           (d) The Department may adopt rules as necessary to  
23 implement and administer this Section.

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

25           (215 ILCS 5/367a) (from Ch. 73, par. 979a)

1           Sec. 367a. Blanket accident and health insurance.

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

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

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

14           (c) Under a policy or contract issued to a college,  
15 school, or other institution of learning or to the head or  
16 principal thereof, who or which shall be deemed the  
17 policyholder, covering students or teachers. However,  
18 student health insurance coverage, as defined in 45 CFR  
19 147.145, shall remain subject to the standards and  
20 requirements for individual health insurance coverage  
21 except where inconsistent with that regulation. Student  
22 health insurance coverage shall not be subject to the  
23 Short-Term, Limited-Duration Health Insurance Coverage  
24 Act. An insurer providing student health insurance  
25 coverage or a policy or contract covering students for  
26 limited-scope dental or vision under 45 CFR 148.220 shall

1       require an individual application or enrollment form and  
2       shall furnish each insured individual a certificate, which  
3       shall have been approved by the Director under Section  
4       355.

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

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

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

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

23       (2) Any insurance company authorized to write accident and  
24       health insurance in this state shall have the power to issue  
25       blanket accident and health insurance. No such blanket policy  
26       may be issued or delivered in this State unless a copy of the



1 form thereof shall have been filed in accordance with Section  
2 355, and it contains in substance such of those provisions  
3 contained in Sections 357.1 through 357.30 as may be  
4 applicable to blanket accident and health insurance and the  
5 following provisions:

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

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

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

20 (3.5) Subsection (3) does not apply to major medical  
21 insurance, or to any excepted benefits or short-term,  
22 limited-duration health insurance coverage for which an  
23 insured individual pays premiums or contributions. In those  
24 cases, the insurer shall require an individual application or  
25 enrollment form and shall furnish each insured individual a  
26 certificate, which shall have been approved by the Director

1 under Section 355 of this Code.

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

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

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

21 (215 ILCS 5/370e) (from Ch. 73, par. 982e)

22 Sec. 370e. Companies which issue group accident and health  
23 policies or blanket accident and health plans to employer  
24 groups in this State shall provide the employer with notice of  
25 termination of a group or blanket accident and health plan

1 because of the employer's failure to pay the premium when due.  
2 The insurance company shall file ~~send~~ a copy of such notice  
3 with ~~to~~ the Department in an electronic format either through  
4 the System for Electronic Rate and Form Filing (SERFF) or as  
5 otherwise prescribed by the Director.

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

7 (215 ILCS 5/370i) (from Ch. 73, par. 982i)

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

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

14 (b) An insurer or administrator may:

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

21 (2) issue or administer programs, policies or  
22 subscriber contracts in this State that include incentives  
23 for the insured or beneficiary to utilize the services of  
24 a provider which has entered into an agreement with the  
25 insurer or administrator pursuant to paragraph (1) above.

1           (c) (Blank). ~~After the effective date of this amendatory~~  
2 ~~Act of the 92nd General Assembly, any insurer that arranges,~~  
3 ~~contracts with, or administers contracts with a provider~~  
4 ~~whereby beneficiaries are provided an incentive to use the~~  
5 ~~services of such provider must include the following~~  
6 ~~disclosure on its contracts and evidences of coverage:~~  
7 ~~"WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON PARTICIPATING~~  
8 ~~PROVIDERS ARE USED. You should be aware that when you elect to~~  
9 ~~utilize the services of a non-participating provider for a~~  
10 ~~covered service in non-emergency situations, benefit payments~~  
11 ~~to such non-participating provider are not based upon the~~  
12 ~~amount billed. The basis of your benefit payment will be~~  
13 ~~determined according to your policy's fee schedule, usual and~~  
14 ~~customary charge (which is determined by comparing charges for~~  
15 ~~similar services adjusted to the geographical area where the~~  
16 ~~services are performed), or other method as defined by the~~  
17 ~~policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT~~  
18 ~~DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED~~  
19 ~~PORTION. Non participating providers may bill members for any~~  
20 ~~amount up to the billed charge after the plan has paid its~~  
21 ~~portion of the bill. Participating providers have agreed to~~  
22 ~~accept discounted payments for services with no additional~~  
23 ~~billing to the member other than co-insurance and deductible~~  
24 ~~amounts. You may obtain further information about the~~  
25 ~~participating status of professional providers and information~~  
26 ~~on out of pocket expenses by calling the toll free telephone~~

1 ~~number on your identification card."~~

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

3 (215 ILCS 5/408) (from Ch. 73, par. 1020)

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

5 Sec. 408. Fees and charges.

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

9 (a) For filing all documents submitted for the  
10 incorporation or organization or certification of a  
11 domestic company, except for a fraternal benefit society,  
12 \$2,000.

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

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

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

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

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

1 (g) For filing agreement of merger or consolidation:

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

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

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

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

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

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

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

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

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

26 (n) For filing annual statement by a farm mutual, a

1 mutual benefit association, or a burial society, \$50.

2 (o) For issuing a certificate of authority or renewal  
3 thereof except to a foreign fraternal benefit society,  
4 \$400.

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

7 (q) For issuing an amended certificate of authority,  
8 \$50.

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

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

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

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

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

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

25 (i) in connection with a public stock offering,  
26 \$300;

1 (ii) in any other case, \$100.

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

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

8 (z) For filing a statement of acquisition of a  
9 domestic company as defined in Section 131.4 of this Code,  
10 \$2,000.

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

16 (bb) For filing a statement of acquisition of a  
17 foreign or alien insurance company as defined in Section  
18 131.12a of this Code, \$1,000.

19 (cc) For filing a registration statement as required  
20 in Sections 131.13 and 131.14, the notification as  
21 required by Sections 131.16, 131.20a, or 141.4, or an  
22 agreement or transaction required by Sections 124.2(2),  
23 141, 141a, or 141.1, \$200.

24 (dd) For filing an application for licensing of:

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



1           (ii) a workers' compensation service company,  
2           \$500;

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

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

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

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

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

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

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

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

25          (i) For the purposes of the form filing fee,  
26          filings made on insert page basis will be considered

1 one form at the time of its original submission.  
2 Changes made to a form subsequent to its approval  
3 shall be considered a new filing.

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

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

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

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

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

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

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

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

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

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

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

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

14          (3) The expenses incurred in any performance examination  
15          authorized by law shall be paid by the company or person being  
16          examined. The charge shall be reasonably related to the cost  
17          of the examination including but not limited to compensation  
18          of examiners, electronic data processing costs, supervision  
19          and preparation of an examination report and lodging and  
20          travel expenses. All lodging and travel expenses shall be in  
21          accord with the applicable travel regulations as published by  
22          the Department of Central Management Services and approved by  
23          the Governor's Travel Control Board, except that out-of-state  
24          lodging and travel expenses related to examinations authorized  
25          under Section 132 shall be in accordance with travel rates  
26          prescribed under paragraph 301-7.2 of the Federal Travel

1 Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of  
2 subsistence expenses incurred during official travel. All  
3 lodging and travel expenses may be reimbursed directly upon  
4 authorization of the Director. With the exception of the  
5 direct reimbursements authorized by the Director, all  
6 performance examination charges collected by the Department  
7 shall be paid to the Insurance Producer Administration Fund,  
8 however, the electronic data processing costs incurred by the  
9 Department in the performance of any examination shall be  
10 billed directly to the company being examined for payment to  
11 the Technology Management Revolving Fund.

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

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

26 (b) For purposes of this subsection (5) costs incurred

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

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

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

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

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

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

17           (ii) \$750, if the premium is \$500,000 or more, but  
18 less than \$5,000,000 and there is no reinsurance  
19 assumed premium; or if the premium is less than  
20 \$5,000,000 and the reinsurance assumed premium is less  
21 than \$10,000,000;

22           (iii) \$3,750, if the premium is less than  
23 \$5,000,000 and the reinsurance assumed premium is  
24 \$10,000,000 or more;

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

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

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

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

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

9 (b) Admitted assets.

10 (i) \$150, if admitted assets are less than  
11 \$1,000,000;

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

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

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

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

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

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

24 (viii) \$37,500, if admitted assets are  
25 \$1,000,000,000 or more.

26 (c) The sum of financial regulation fees charged to

1 the domestic companies of the same affiliated group shall  
2 not exceed \$250,000 in the aggregate in any single year  
3 and shall be billed by the Director to the member company  
4 designated by the group.

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

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

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

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

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

26 (e) \$18,000, if the premium is \$10,000,000 or more,



1 but less than \$25,000,000;

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

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

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

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

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

25 (9) In addition to the financial regulation fee required  
26 by this Section, a company undergoing any financial

1 examination authorized by law shall pay the following costs  
2 and expenses incurred by the Department: electronic data  
3 processing costs, the expenses authorized under Section 131.21  
4 and subsection (d) of Section 132.4 of this Code, and lodging  
5 and travel expenses.

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

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

26 In the case of an organization or person not subject to the

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

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

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

14 (12) For purposes of this Section:

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

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

1 which is incorporated or organized under the laws of any  
2 state of the United States other than this State.

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

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

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

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

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

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

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

24 Sec. 408. Fees and charges.

25 (1) The Director shall charge, collect and give proper

1 acquittances for the payment of the following fees and  
2 charges:

3 (a) For filing all documents submitted for the  
4 incorporation or organization or certification of a  
5 domestic company, except for a fraternal benefit society,  
6 \$2,000.

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

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

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

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

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

20 (g) For filing agreement of merger or consolidation:

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

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

26 (iii) for a fraternal benefit society, a mutual

1 benefit association, a burial society, or a farm  
2 mutual, \$200.

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

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

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

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

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

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

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

21 (o) For issuing a certificate of authority or renewal  
22 thereof except to a foreign fraternal benefit society,  
23 \$400.

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

26 (q) For issuing an amended certificate of authority,

1           \$50.

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

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

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

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

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

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

18           (i) in connection with a public stock offering,  
19 \$300;

20           (ii) in any other case, \$100.

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

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

1           (z) For filing a statement of acquisition of a  
2 domestic company as defined in Section 131.4 of this Code,  
3 \$2,000.

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

9           (bb) For filing a statement of acquisition of a  
10 foreign or alien insurance company as defined in Section  
11 131.12a of this Code, \$1,000.

12           (cc) For filing a registration statement as required  
13 in Sections 131.13 and 131.14, the notification as  
14 required by Sections 131.16, 131.20a, or 141.4, or an  
15 agreement or transaction required by Sections 124.2(2),  
16 141, 141a, or 141.1, \$200.

17           (dd) For filing an application for licensing of:

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

20               (ii) a workers' compensation service company,  
21 \$500;

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

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

25           (ee) For filing articles of incorporation for a  
26 syndicate to engage in the business of insurance through



1 the Illinois Insurance Exchange, \$2,000.

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

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

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

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

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

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

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

26 (iii) Fees charged for a policy filed as it will be

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

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

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

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

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

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

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

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

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

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

26 (ss) For filing an insurance business transfer plan

1 under Article XLVII, \$100,000 ~~\$25,000~~.

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

9 (3) The expenses incurred in any performance examination  
10 authorized by law shall be paid by the company or person being  
11 examined. The charge shall be reasonably related to the cost  
12 of the examination including but not limited to compensation  
13 of examiners, electronic data processing costs, supervision  
14 and preparation of an examination report and lodging and  
15 travel expenses. All lodging and travel expenses shall be in  
16 accord with the applicable travel regulations as published by  
17 the Department of Central Management Services and approved by  
18 the Governor's Travel Control Board, except that out-of-state  
19 lodging and travel expenses related to examinations authorized  
20 under Section 132 shall be in accordance with travel rates  
21 prescribed under paragraph 301-7.2 of the Federal Travel  
22 Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of  
23 subsistence expenses incurred during official travel. All  
24 lodging and travel expenses may be reimbursed directly upon  
25 authorization of the Director. With the exception of the  
26 direct reimbursements authorized by the Director, all

1 performance examination charges collected by the Department  
2 shall be paid to the Insurance Producer Administration Fund,  
3 however, the electronic data processing costs incurred by the  
4 Department in the performance of any examination shall be  
5 billed directly to the company being examined for payment to  
6 the Technology Management Revolving Fund.

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

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

21 (b) For purposes of this subsection (5) costs incurred  
22 shall mean the hearing officer fees, court reporter fees, and  
23 travel expenses of Department of Insurance officers and  
24 employees; provided however, that costs incurred shall not  
25 include hearing officer fees or court reporter fees unless the  
26 Department has retained the services of independent

1 contractors or outside experts to perform such functions.

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

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

22 (6) The Director shall charge and collect an annual  
23 financial regulation fee from every domestic company for  
24 examination and analysis of its financial condition and to  
25 fund the internal costs and expenses of the Interstate  
26 Insurance Receivership Commission as may be allocated to the

1 State of Illinois and companies doing an insurance business in  
2 this State pursuant to Article X of the Interstate Insurance  
3 Receivership Compact. The fee shall be the greater fixed  
4 amount based upon the combination of nationwide direct premium  
5 income and nationwide reinsurance assumed premium income or  
6 upon admitted assets calculated under this subsection as  
7 follows:

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

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

12 (ii) \$750, if the premium is \$500,000 or more, but  
13 less than \$5,000,000 and there is no reinsurance  
14 assumed premium; or if the premium is less than  
15 \$5,000,000 and the reinsurance assumed premium is less  
16 than \$10,000,000;

17 (iii) \$3,750, if the premium is less than  
18 \$5,000,000 and the reinsurance assumed premium is  
19 \$10,000,000 or more;

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

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

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

26 (vii) \$30,000, if the premium is \$50,000,000 or

1 more, but less than \$100,000,000;

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

4 (b) Admitted assets.

5 (i) \$150, if admitted assets are less than  
6 \$1,000,000;

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

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

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

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

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

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

19 (viii) \$37,500, if admitted assets are  
20 \$1,000,000,000 or more.

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

26 (7) The Director shall charge and collect an annual

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

1 described in this subsection.

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

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

9 (12) For purposes of this Section:

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

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

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

1 States.

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

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

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

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

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

18 (215 ILCS 5/412) (from Ch. 73, par. 1024)

19 Sec. 412. Refunds; penalties; collection.

20 (1)(a) Whenever it appears to the satisfaction of the  
21 Director that because of some mistake of fact, error in  
22 calculation, or erroneous interpretation of a statute of this  
23 or any other state, any authorized company, surplus line  
24 producer, or industrial insured has paid to him, pursuant to  
25 any provision of law, taxes, fees, or other charges in excess

1 of the amount legally chargeable against it, during the 6-year  
2 ~~6-year~~ period immediately preceding the discovery of such  
3 overpayment, he shall have power to refund to such company,  
4 surplus line producer, or industrial insured the amount of the  
5 excess or excesses by applying the amount or amounts thereof  
6 toward the payment of taxes, fees, or other charges already  
7 due, or which may thereafter become due from that company  
8 until such excess or excesses have been fully refunded, or  
9 upon a written request from the authorized company, surplus  
10 line producer, or industrial insured, the Director shall  
11 provide a cash refund within 120 days after receipt of the  
12 written request if all necessary information has been filed  
13 with the Department in order for it to perform an audit of the  
14 tax report for the transaction or period or annual return for  
15 the year in which the overpayment occurred or within 120 days  
16 after the date the Department receives all the necessary  
17 information to perform such audit. The Director shall not  
18 provide a cash refund if there are insufficient funds in the  
19 Insurance Premium Tax Refund Fund to provide a cash refund, if  
20 the amount of the overpayment is less than \$100, or if the  
21 amount of the overpayment can be fully offset against the  
22 taxpayer's estimated liability for the year following the year  
23 of the cash refund request. Any cash refund shall be paid from  
24 the Insurance Premium Tax Refund Fund, a special fund hereby  
25 created in the State treasury.

26 (b) As determined by the Director pursuant to paragraph

1 (a) of this subsection, the Department shall deposit an amount  
2 of cash refunds approved by the Director for payment as a  
3 result of overpayment of tax liability collected under  
4 Sections 121-2.08, 409, 444, 444.1, and 445 of this Code into  
5 the Insurance Premium Tax Refund Fund.

6 (c) Beginning July 1, 1999, moneys in the Insurance  
7 Premium Tax Refund Fund shall be expended exclusively for the  
8 purpose of paying cash refunds resulting from overpayment of  
9 tax liability under Sections 121-2.08, 409, 444, 444.1, and  
10 445 of this Code as determined by the Director pursuant to  
11 subsection 1(a) of this Section. Cash refunds made in  
12 accordance with this Section may be made from the Insurance  
13 Premium Tax Refund Fund only to the extent that amounts have  
14 been deposited and retained in the Insurance Premium Tax  
15 Refund Fund.

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

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

1 of the tax due, whichever is greater. In this paragraph, "tax  
2 due" means the full amount due for that year under Section  
3 408.1, 409, 444, or 444.1 of this Code or Section 12 of the  
4 Fire Investigation Act.

5 (b) When any industrial insured or surplus line producer  
6 fails to file any tax return or report required under Sections  
7 121-2.08 and 445 of this Code or Section 12 of the Fire  
8 Investigation Act on the date prescribed, including any  
9 extensions, there shall be added:

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

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

18 (iii) as a penalty, if the return or report is  
19 received more than 30 days after the prescribed due date,  
20 \$100 or 5% of the tax due, whichever is greater, for each  
21 month or part of a month of failure to file, the entire  
22 penalty not to exceed \$500 or 30% of the tax due, whichever  
23 is greater.

24 In this paragraph, "tax due" means the full amount due for  
25 that year under Section 121-2.08 or 445 of this Code or Section  
26 12 of the Fire Investigation Act. A tax return or report shall

1 be deemed received as of the date mailed as evidenced by a  
2 postmark, proof of mailing on a recognized United States  
3 Postal Service form or a form acceptable to the United States  
4 Postal Service or other commercial mail delivery service, or  
5 other evidence acceptable to the Director.

6 (3)(a) When any insurance company fails to pay the full  
7 amount due under the provisions of this Section, Sections  
8 408.1, 409, 444, or 444.1 of this Code, or Section 12 of the  
9 Fire Investigation Act, there shall be added to the amount due  
10 as a penalty an amount equal to 10% of the deficiency.

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

16 (i) as a late fee, if the payment is received at least  
17 one day but not more than 7 days after the prescribed due  
18 date, 10% of the tax due, the entire fee not to exceed  
19 \$1,000;

20 (ii) as a late fee, if the payment is received at least  
21 8 days but not more than 14 days after the prescribed due  
22 date, 10% of the tax due, the entire fee not to exceed  
23 \$1,500;

24 (iii) as a late fee, if the payment is received at  
25 least 15 days but not more than 21 days after the  
26 prescribed due date, 10% of the tax due, the entire fee not



1 to exceed \$2,000; or

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

5 In this paragraph, "tax due" means the full amount due for  
6 that year under this Section, Section 121-2.08 or 445 of this  
7 Code, or Section 12 of the Fire Investigation Act. A tax  
8 payment shall be deemed received as of the date mailed as  
9 evidenced by a postmark, proof of mailing on a recognized  
10 United States Postal Service form or a form acceptable to the  
11 United States Postal Service or other commercial mail delivery  
12 service, or other evidence acceptable to the Director.

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

21 (4) Any insurance company, industrial insured, or surplus  
22 line producer that fails to pay the full amount due under this  
23 Section or Sections 121-2.08, 408.1, 409, 444, 444.1, or 445  
24 of this Code, or Section 12 of the Fire Investigation Act is  
25 liable, in addition to the tax and any late fees and penalties,  
26 for interest on such deficiency at the rate of 12% per annum,

1 or at such higher adjusted rates as are or may be established  
2 under subsection (b) of Section 6621 of the Internal Revenue  
3 Code, from the date that payment of any such tax was due,  
4 determined without regard to any extensions, to the date of  
5 payment of such amount.

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

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

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

26 (8) The Department shall have a lien for the taxes, fees,

1 charges, fines, penalties, interest, other charges, or any  
2 portion thereof, imposed or assessed pursuant to this Code,  
3 upon all the real and personal property of any company or  
4 person to whom the assessment or final order has been issued or  
5 whenever a tax return is filed without payment of the tax or  
6 penalty shown therein to be due, including all such property  
7 of the company or person acquired after receipt of the  
8 assessment, issuance of the order, or filing of the return.  
9 The company or person is liable for the filing fee incurred by  
10 the Department for filing the lien and the filing fee incurred  
11 by the Department to file the release of that lien. The filing  
12 fees shall be paid to the Department in addition to payment of  
13 the tax, fee, charge, fine, penalty, interest, other charges,  
14 or any portion thereof, included in the amount of the lien.  
15 However, where the lien arises because of the issuance of a  
16 final order of the Director or tax assessment by the  
17 Department, the lien shall not attach and the notice referred  
18 to in this Section shall not be filed until all administrative  
19 proceedings or proceedings in court for review of the final  
20 order or assessment have terminated or the time for the taking  
21 thereof has expired without such proceedings being instituted.

22 Upon the granting of Department review after a lien has  
23 attached, the lien shall remain in full force except to the  
24 extent to which the final assessment may be reduced by a  
25 revised final assessment following the rehearing or review.  
26 The lien created by the issuance of a final assessment shall

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

15 The time limitation period on the Department's right to  
16 file a notice of lien shall not run during any period of time  
17 in which the order of any court has the effect of enjoining or  
18 restraining the Department from filing such notice of lien. If  
19 the Department finds that a company or person is about to  
20 depart from the State, to conceal himself or his property, or  
21 to do any other act tending to prejudice or to render wholly or  
22 partly ineffectual proceedings to collect the amount due and  
23 owing to the Department unless such proceedings are brought  
24 without delay, or if the Department finds that the collection  
25 of the amount due from any company or person will be  
26 jeopardized by delay, the Department shall give the company or

1 person notice of such findings and shall make demand for  
2 immediate return and payment of the amount, whereupon the  
3 amount shall become immediately due and payable. If the  
4 company or person, within 5 days after the notice (or within  
5 such extension of time as the Department may grant), does not  
6 comply with the notice or show to the Department that the  
7 findings in the notice are erroneous, the Department may file  
8 a notice of jeopardy assessment lien in the office of the  
9 recorder of the county in which any property of the company or  
10 person may be located and shall notify the company or person of  
11 the filing. The jeopardy assessment lien shall have the same  
12 scope and effect as the statutory lien provided for in this  
13 Section. If the company or person believes that the company or  
14 person does not owe some or all of the tax for which the  
15 jeopardy assessment lien against the company or person has  
16 been filed, or that no jeopardy to the revenue in fact exists,  
17 the company or person may protest within 20 days after being  
18 notified by the Department of the filing of the jeopardy  
19 assessment lien and request a hearing, whereupon the  
20 Department shall hold a hearing in conformity with the  
21 provisions of this Code and, pursuant thereto, shall notify  
22 the company or person of its findings as to whether or not the  
23 jeopardy assessment lien will be released. If not, and if the  
24 company or person is aggrieved by this decision, the company  
25 or person may file an action for judicial review of the final  
26 determination of the Department in accordance with the

1 Administrative Review Law. If, pursuant to such hearing (or  
2 after an independent determination of the facts by the  
3 Department without a hearing), the Department determines that  
4 some or all of the amount due covered by the jeopardy  
5 assessment lien is not owed by the company or person, or that  
6 no jeopardy to the revenue exists, or if on judicial review the  
7 final judgment of the court is that the company or person does  
8 not owe some or all of the amount due covered by the jeopardy  
9 assessment lien against them, or that no jeopardy to the  
10 revenue exists, the Department shall release its jeopardy  
11 assessment lien to the extent of such finding of nonliability  
12 for the amount, or to the extent of such finding of no jeopardy  
13 to the revenue. The Department shall also release its jeopardy  
14 assessment lien against the company or person whenever the  
15 amount due and owing covered by the lien, plus any interest  
16 which may be due, are paid and the company or person has paid  
17 the Department in cash or by guaranteed remittance an amount  
18 representing the filing fee for the lien and the filing fee for  
19 the release of that lien. The Department shall file that  
20 release of lien with the recorder of the county where that lien  
21 was filed.

22 Nothing in this Section shall be construed to give the  
23 Department a preference over the rights of any bona fide  
24 purchaser, holder of a security interest, mechanics  
25 lienholder, mortgagee, or judgment lien creditor arising prior  
26 to the filing of a regular notice of lien or a notice of

1 jeopardy assessment lien in the office of the recorder in the  
2 county in which the property subject to the lien is located.  
3 For purposes of this Section, "bona fide" shall not include  
4 any mortgage of real or personal property or any other credit  
5 transaction that results in the mortgagee or the holder of the  
6 security acting as trustee for unsecured creditors of the  
7 company or person mentioned in the notice of lien who executed  
8 such chattel or real property mortgage or the document  
9 evidencing such credit transaction. The lien shall be inferior  
10 to the lien of general taxes, special assessments, and special  
11 taxes levied by any political subdivision of this State. In  
12 case title to land to be affected by the notice of lien or  
13 notice of jeopardy assessment lien is registered under the  
14 provisions of the Registered Titles (Torrens) Act, such notice  
15 shall be filed in the office of the Registrar of Titles of the  
16 county within which the property subject to the lien is  
17 situated and shall be entered upon the register of titles as a  
18 memorial or charge upon each folium of the register of titles  
19 affected by such notice, and the Department shall not have a  
20 preference over the rights of any bona fide purchaser,  
21 mortgagee, judgment creditor, or other lienholder arising  
22 prior to the registration of such notice. The regular lien or  
23 jeopardy assessment lien shall not be effective against any  
24 purchaser with respect to any item in a retailer's stock in  
25 trade purchased from the retailer in the usual course of the  
26 retailer's business.

1 (Source: P.A. 102-775, eff. 5-13-22; 103-426, eff. 8-4-23.)

2 (215 ILCS 5/531.03) (from Ch. 73, par. 1065.80-3)

3 Sec. 531.03. Coverage and limitations.

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

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

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

17 (i) are residents; or

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

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

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

25 (C) the persons are not eligible for coverage



1           by an association in any other state due to the  
2           fact that the insurer or health maintenance  
3           organization was not licensed in that state at the  
4           time specified in that state's guaranty  
5           association law.

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

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

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

19           (d) For structured settlement annuities specified in  
20          subsection (2), paragraphs (a) and (b) of this subsection  
21          (1) shall not apply and this Article shall (except as  
22          provided in paragraphs (e) and (f) of this subsection)  
23          provide coverage to a person who is a payee under a  
24          structured settlement annuity (or beneficiary of a payee  
25          if the payee is deceased), if the payee:

26           (i) is a resident, regardless of where the

1 contract owner resides; or

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

4 (A) with regard to residency:

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

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

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

18 (e) This Article shall not provide coverage to:

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

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

26 (f) This Article is intended to provide coverage to a

1 person who is a resident of this State and, in special  
2 circumstances, to a nonresident. In order to avoid  
3 duplicate coverage, if a person who would otherwise  
4 receive coverage under this Article is provided coverage  
5 under the laws of any other state, then the person shall  
6 not be provided coverage under this Article. In  
7 determining the application of the provisions of this  
8 paragraph in situations where a person could be covered by  
9 the association of more than one state, whether as an  
10 owner, payee, enrollee, beneficiary, or assignee, this  
11 Article shall be construed in conjunction with other state  
12 laws to result in coverage by only one association.

13 (2)(a) This Article shall provide coverage to the persons  
14 specified in subsection (1) of this Section for policies or  
15 contracts of direct, (i) nongroup life insurance, health  
16 insurance (that, for the purposes of this Article, includes  
17 health maintenance organization subscriber contracts and  
18 certificates), annuities and supplemental contracts to any of  
19 these, (ii) for certificates under direct group policies or  
20 contracts, (iii) for unallocated annuity contracts and (iv)  
21 for contracts to furnish health care services and subscription  
22 certificates for medical or health care services issued by  
23 persons licensed to transact insurance business in this State  
24 under this Code. Annuity contracts and certificates under  
25 group annuity contracts include but are not limited to  
26 guaranteed investment contracts, deposit administration

1 contracts, unallocated funding agreements, allocated funding  
2 agreements, structured settlement agreements, lottery  
3 contracts and any immediate or deferred annuity contracts.

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

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

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

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

19 (A) averaged over the period of 4 years prior to  
20 the date on which the member insurer becomes an  
21 impaired or insolvent insurer under this Article,  
22 whichever is earlier, exceeds the rate of interest  
23 determined by subtracting 2 percentage points from  
24 Moody's Corporate Bond Yield Average averaged for that  
25 same 4-year period or for such lesser period if the  
26 policy or contract was issued less than 4 years before

1 the member insurer becomes an impaired or insolvent  
2 insurer under this Article, whichever is earlier; and

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

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

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

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

24 (A) a claim based on marketing materials;

25 (B) a claim based on side letters, riders, or  
26 other documents that were issued by the member insurer

1 without meeting applicable policy or contract form  
2 filing or approval requirements;

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

5 (D) an extra-contractual claim; or

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

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

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

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

22 (x) any portion of a policy or contract issued to a  
23 plan or program of an employer, association, or other  
24 person to provide life, health, or annuity benefits to its  
25 employees, members, or others to the extent that the plan  
26 or program is self-funded or uninsured, including, but not

1 limited to, benefits payable by an employer, association,  
2 or other person under:

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

5 (B) a minimum premium group insurance plan;

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

7 (D) an administrative services only contract;

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

10 (A) dividends or experience rating credits;

11 (B) voting rights; or

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

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

20 (xiii) any contractual agreement that establishes the  
21 member insurer's obligations to provide a book value  
22 accounting guaranty for defined contribution benefit plan  
23 participants by reference to a portfolio of assets that is  
24 owned by the benefit plan or its trustee, which in each  
25 case is not an affiliate of the member insurer;

26 (xiv) any portion of a policy or contract to the

1 extent that it provides for interest or other changes in  
2 value to be determined by the use of an index or other  
3 external reference stated in the policy or contract, but  
4 which have not been credited to the policy or contract, or  
5 as to which the policy or contract owner's rights are  
6 subject to forfeiture, as of the date the member insurer  
7 becomes an impaired or insolvent insurer under this Code,  
8 whichever is earlier. If a policy's or contract's interest  
9 or changes in value are credited less frequently than  
10 annually, then for purposes of determining the values that  
11 have been credited and are not subject to forfeiture under  
12 this Section, the interest or change in value determined  
13 by using the procedures defined in the policy or contract  
14 will be credited as if the contractual date of crediting  
15 interest or changing values was the date of impairment or  
16 insolvency, whichever is earlier, and will not be subject  
17 to forfeiture; or

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

21 (c) The exclusion from coverage referenced in subdivision  
22 (iii) of paragraph (b) of this subsection shall not apply to  
23 any portion of a policy or contract, including a rider, that  
24 provides long-term care or other health insurance benefits.

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



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

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

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

9               (B) for health insurance benefits:

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

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

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

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

20           (ii) with respect to each individual participating in  
21 a governmental retirement benefit plan established under  
22 Section 401, 403(b), or 457 of the U.S. Internal Revenue  
23 Code covered by an unallocated annuity contract or the  
24 beneficiaries of each such individual if deceased, in the  
25 aggregate, \$250,000 in present value annuity benefits,  
26 including net cash surrender and net cash withdrawal

1 values;

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

7 (iv) with respect to either (1) one contract owner  
8 provided coverage under subparagraph (ii) of paragraph (c)  
9 of subsection (1) of this Section or (2) one plan sponsor  
10 whose plans own directly or in trust one or more  
11 unallocated annuity contracts not included in subparagraph  
12 (ii) of paragraph (b) of this subsection, \$5,000,000 in  
13 benefits, irrespective of the number of contracts with  
14 respect to the contract owner or plan sponsor. However, in  
15 the case where one or more unallocated annuity contracts  
16 are covered contracts under this Article and are owned by  
17 a trust or other entity for the benefit of 2 or more plan  
18 sponsors, coverage shall be afforded by the Association if  
19 the largest interest in the trust or entity owning the  
20 contract or contracts is held by a plan sponsor whose  
21 principal place of business is in this State. In no event  
22 shall the Association be obligated to cover more than  
23 \$5,000,000 in benefits with respect to all these  
24 unallocated contracts.

25 In no event shall the Association be obligated to cover  
26 more than (1) an aggregate of \$300,000 in benefits with

1 respect to any one life under subparagraphs (i), (ii), and  
2 (iii) of this paragraph (b) except with respect to benefits  
3 for health benefit plans under item (B) of subparagraph (i) of  
4 this paragraph (b), in which case the aggregate liability of  
5 the Association shall not exceed \$500,000 with respect to any  
6 one individual or (2) with respect to one owner of multiple  
7 nongroup policies of life insurance, whether the policy or  
8 contract owner is an individual, firm, corporation, or other  
9 person and whether the persons insured are officers, managers,  
10 employees, or other persons, \$5,000,000 in benefits,  
11 regardless of the number of policies and contracts held by the  
12 owner.

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

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

1 relates.

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

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

11 (215 ILCS 5/356z.30a rep.)

12 (215 ILCS 5/362a rep.)

13 Section 26. The Illinois Insurance Code is amended by  
14 repealing Sections 356z.30a and 362a.

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

17 (215 ILCS 124/5)

18 Sec. 5. Definitions. In this Act:

19 "Authorized representative" means a person to whom a  
20 beneficiary has given express written consent to represent the  
21 beneficiary; a person authorized by law to provide substituted  
22 consent for a beneficiary; or the beneficiary's treating  
23 provider only when the beneficiary or his or her family member

1 is unable to provide consent.

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

9 "Department" means the Department of Insurance.

10 "Director" means the Director of Insurance.

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

17 "Insurer" means any entity that offers individual or group  
18 accident and health insurance, including, but not limited to,  
19 health maintenance organizations, preferred provider  
20 organizations, exclusive provider organizations, and other  
21 plan structures requiring network participation, excluding the  
22 medical assistance program under the Illinois Public Aid Code,  
23 the State employees group health insurance program, workers  
24 compensation insurance, and pharmacy benefit managers.

25 "Material change" means a significant reduction in the  
26 number of providers available in a network plan, including,

1 but not limited to, a reduction of 10% or more in a specific  
2 type of providers, the removal of a major health system that  
3 causes a network to be significantly different from the  
4 network when the beneficiary purchased the network plan, or  
5 any change that would cause the network to no longer satisfy  
6 the requirements of this Act or the Department's rules for  
7 network adequacy and transparency.

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

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

15 "Ongoing course of treatment" means (1) treatment for a  
16 life-threatening condition, which is a disease or condition  
17 for which likelihood of death is probable unless the course of  
18 the disease or condition is interrupted; (2) treatment for a  
19 serious acute condition, defined as a disease or condition  
20 requiring complex ongoing care that the covered person is  
21 currently receiving, such as chemotherapy, radiation therapy,  
22 or post-operative visits; (3) a course of treatment for a  
23 health condition that a treating provider attests that  
24 discontinuing care by that provider would worsen the condition  
25 or interfere with anticipated outcomes; or (4) the third  
26 trimester of pregnancy through the post-partum period.

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

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

10 "Telehealth" has the meaning given to that term in Section  
11 356z.22 of the Illinois Insurance Code.

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

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

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

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

23 (215 ILCS 124/10)

24 Sec. 10. Network adequacy.

25 (a) An insurer providing a network plan shall file a

1 description of all of the following with the Director:

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

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

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

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

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

25 (1) A geographic map of the area proposed to be served  
26 by the plan by county service area and zip code, including



1 marked locations for preferred providers.

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

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

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

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

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

19 (B) the ratio of physicians and other providers to  
20 beneficiaries, by specialty and including primary care  
21 physicians and facility-based physicians when  
22 applicable under the contract, necessary to meet the  
23 health care needs and service demands of the currently  
24 enrolled population;

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

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

5           (6) A provision ensuring that whenever a beneficiary  
6           has made a good faith effort, as evidenced by accessing  
7           the provider directory, calling the network plan, and  
8           calling the provider, to utilize preferred providers for a  
9           covered service and it is determined the insurer does not  
10          have the appropriate preferred providers due to  
11          insufficient number, type, unreasonable travel distance or  
12          delay, or preferred providers refusing to provide a  
13          covered service because it is contrary to the conscience  
14          of the preferred providers, as protected by the Health  
15          Care Right of Conscience Act, the insurer shall ensure,  
16          directly or indirectly, by terms contained in the payer  
17          contract, that the beneficiary will be provided the  
18          covered service at no greater cost to the beneficiary than  
19          if the service had been provided by a preferred provider.  
20          This paragraph (6) does not apply to: (A) a beneficiary  
21          who willfully chooses to access a non-preferred provider  
22          for health care services available through the panel of  
23          preferred providers, or (B) a beneficiary enrolled in a  
24          health maintenance organization. In these circumstances,  
25          the contractual requirements for non-preferred provider  
26          reimbursements shall apply unless Section 356z.3a of the

1 Illinois Insurance Code requires otherwise. In no event  
2 shall a beneficiary who receives care at a participating  
3 health care facility be required to search for  
4 participating providers under the circumstances described  
5 in subsection (b) or (b-5) of Section 356z.3a of the  
6 Illinois Insurance Code except under the circumstances  
7 described in paragraph (2) of subsection (b-5).

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

20 (8) A limitation that, if the plan provides that the  
21 beneficiary will incur a penalty for failing to  
22 pre-certify inpatient hospital treatment, the penalty may  
23 not exceed \$1,000 per occurrence in addition to the plan  
24 cost-sharing ~~cost sharing~~ provisions.

25 (c) The network plan shall demonstrate to the Director a  
26 minimum ratio of providers to plan beneficiaries as required

1 by the Department.

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

- 11 (A) Primary Care;
- 12 (B) Pediatrics;
- 13 (C) Cardiology;
- 14 (D) Gastroenterology;
- 15 (E) General Surgery;
- 16 (F) Neurology;
- 17 (G) OB/GYN;
- 18 (H) Oncology/Radiation;
- 19 (I) Ophthalmology;
- 20 (J) Urology;
- 21 (K) Behavioral Health;
- 22 (L) Allergy/Immunology;
- 23 (M) Chiropractic;
- 24 (N) Dermatology;
- 25 (O) Endocrinology;
- 26 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

- 1 (Q) Infectious Disease;  
2 (R) Nephrology;  
3 (S) Neurosurgery;  
4 (T) Orthopedic Surgery;  
5 (U) Physiatry/Rehabilitative;  
6 (V) Plastic Surgery;  
7 (W) Pulmonary;  
8 (X) Rheumatology;  
9 (Y) Anesthesiology;  
10 (Z) Pain Medicine;  
11 (AA) Pediatric Specialty Services;  
12 (BB) Outpatient Dialysis; and  
13 (CC) HIV.

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

18 (d) The network plan shall demonstrate to the Director  
19 maximum travel and distance standards for plan beneficiaries,  
20 which shall be established annually by the Department in  
21 consultation with the Department of Public Health based upon  
22 the guidance from the federal Centers for Medicare and  
23 Medicaid Services. These standards shall consist of the  
24 maximum minutes or miles to be traveled by a plan beneficiary  
25 for each county type, such as large counties, metro counties,  
26 or rural counties as defined by Department rule.

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

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

8           (d-5)(1) Every insurer shall ensure that beneficiaries  
9 have timely and proximate access to treatment for mental,  
10 emotional, nervous, or substance use disorders or conditions  
11 in accordance with the provisions of paragraph (4) of  
12 subsection (a) of Section 370c of the Illinois Insurance Code.  
13 Insurers shall use a comparable process, strategy, evidentiary  
14 standard, and other factors in the development and application  
15 of the network adequacy standards for timely and proximate  
16 access to treatment for mental, emotional, nervous, or  
17 substance use disorders or conditions and those for the access  
18 to treatment for medical and surgical conditions. As such, the  
19 network adequacy standards for timely and proximate access  
20 shall equally be applied to treatment facilities and providers  
21 for mental, emotional, nervous, or substance use disorders or  
22 conditions and specialists providing medical or surgical  
23 benefits pursuant to the parity requirements of Section 370c.1  
24 of the Illinois Insurance Code and the federal Paul Wellstone  
25 and Pete Domenici Mental Health Parity and Addiction Equity  
26 Act of 2008. Notwithstanding the foregoing, the network

1 adequacy standards for timely and proximate access to  
2 treatment for mental, emotional, nervous, or substance use  
3 disorders or conditions shall, at a minimum, satisfy the  
4 following requirements:

5 (A) For beneficiaries residing in the metropolitan  
6 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,  
7 network adequacy standards for timely and proximate access  
8 to treatment for mental, emotional, nervous, or substance  
9 use disorders or conditions means a beneficiary shall not  
10 have to travel longer than 30 minutes or 30 miles from the  
11 beneficiary's residence to receive outpatient treatment  
12 for mental, emotional, nervous, or substance use disorders  
13 or conditions. Beneficiaries shall not be required to wait  
14 longer than 10 business days between requesting an initial  
15 appointment and being seen by the facility or provider of  
16 mental, emotional, nervous, or substance use disorders or  
17 conditions for outpatient treatment or to wait longer than  
18 20 business days between requesting a repeat or follow-up  
19 appointment and being seen by the facility or provider of  
20 mental, emotional, nervous, or substance use disorders or  
21 conditions for outpatient treatment; however, subject to  
22 the protections of paragraph (3) of this subsection, a  
23 network plan shall not be held responsible if the  
24 beneficiary or provider voluntarily chooses to schedule an  
25 appointment outside of these required time frames.

26 (B) For beneficiaries residing in Illinois counties

1 other than those counties listed in subparagraph (A) of  
2 this paragraph, network adequacy standards for timely and  
3 proximate access to treatment for mental, emotional,  
4 nervous, or substance use disorders or conditions means a  
5 beneficiary shall not have to travel longer than 60  
6 minutes or 60 miles from the beneficiary's residence to  
7 receive outpatient treatment for mental, emotional,  
8 nervous, or substance use disorders or conditions.  
9 Beneficiaries shall not be required to wait longer than 10  
10 business days between requesting an initial appointment  
11 and being seen by the facility or provider of mental,  
12 emotional, nervous, or substance use disorders or  
13 conditions for outpatient treatment or to wait longer than  
14 20 business days between requesting a repeat or follow-up  
15 appointment and being seen by the facility or provider of  
16 mental, emotional, nervous, or substance use disorders or  
17 conditions for outpatient treatment; however, subject to  
18 the protections of paragraph (3) of this subsection, a  
19 network plan shall not be held responsible if the  
20 beneficiary or provider voluntarily chooses to schedule an  
21 appointment outside of these required time frames.

22 (2) For beneficiaries residing in all Illinois counties,  
23 network adequacy standards for timely and proximate access to  
24 treatment for mental, emotional, nervous, or substance use  
25 disorders or conditions means a beneficiary shall not have to  
26 travel longer than 60 minutes or 60 miles from the



1 beneficiary's residence to receive inpatient or residential  
2 treatment for mental, emotional, nervous, or substance use  
3 disorders or conditions.

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

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

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

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

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

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

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

19           (h) Insurers are required to report to the Director any  
20 material change to an approved network plan within 15 days  
21 after the change occurs and any change that would result in  
22 failure to meet the requirements of this Act. Upon notice from  
23 the insurer, the Director shall reevaluate the network plan's  
24 compliance with the network adequacy and transparency  
25 standards of this Act.

26           (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;

1 102-1117, eff. 1-13-23.)

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

4 (215 ILCS 125/4.5-1)

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

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

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

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

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

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

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

23 (6) may treat as out-of-plan services those services  
24 that an enrollee obtains from a participating provider,

1 but for which the proper authorization was not given by  
2 the health maintenance organization; and

3 (7) after January 1, 2003 (the effective date of  
4 Public Act 92-579), must include the following disclosure  
5 on its point-of-service contracts and evidences of  
6 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN  
7 NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO  
8 PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE  
9 POLICY IN NON-EMERGENCY SITUATIONS. Except in limited  
10 situations governed by the federal No Surprises Act or  
11 Section 356z.3a of the Illinois Insurance Code (215 ILCS  
12 5/356z.3a), non-participating providers furnishing  
13 non-emergency services may bill members for any amount up  
14 to the billed charge after the plan has paid its portion of  
15 the bill. If you elect to use a non-participating  
16 provider, plan benefit payments will be determined  
17 according to your policy's fee schedule, usual and  
18 customary charge (which is determined by comparing charges  
19 for similar services adjusted to the geographical area  
20 where the services are performed), or other method as  
21 defined by the policy. Participating providers have agreed  
22 to ONLY bill members the cost-sharing amounts. You should  
23 ~~be aware that when you elect to utilize the services of a~~  
24 ~~non-participating provider for a covered service in~~  
25 ~~non-emergency situations, benefit payments to such~~  
26 ~~non-participating provider are not based upon the amount~~

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

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

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

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

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

22 (4) A health maintenance organization failing, without  
23 just cause, to comply with the provisions of this  
24 subsection shall be required, after notice and hearing, to  
25 pay a penalty of \$250 for each day out of compliance, to be  
26 recovered by the Director. Any penalty recovered shall be

1           paid into the General Revenue Fund. The Director may  
2           reduce the penalty if the health maintenance organization  
3           demonstrates to the Director that the imposition of the  
4           penalty would constitute a financial hardship to the  
5           health maintenance organization.

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

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

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

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

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

23                   (5) Maintain, in addition to any other deposit  
24                   required under this Act, the deposit required by Section  
25                   2-6.

26                   (6) Maintain cash and cash equivalents of sufficient

1 amount to fully liquidate 10 days' average claim payments,  
2 subject to review by the Director.

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

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

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

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

23 (A) process and pay claims for all out-of-plan  
24 covered services;

25 (B) meet the requirements for point-of-service  
26 contracts set forth in this Section and any additional



1 requirements that may be set forth by the Director;  
2 and

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

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

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

12 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

13 Sec. 5-3. Insurance Code provisions.

14 (a) Health Maintenance Organizations shall be subject to  
15 the provisions of Sections 133, 134, 136, 137, 139, 140,  
16 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,  
17 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49,  
18 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v,  
19 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6,  
20 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14,  
21 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22,  
22 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30,  
23 ~~356z.30a~~, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35,  
24 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41, 356z.44,  
25 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51,

1 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59,  
2 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66,  
3 356z.67, 356z.68, 356z.69, 356z.70, 364, 364.01, 364.3, 367.2,  
4 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1,  
5 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and  
6 444.1, paragraph (c) of subsection (2) of Section 367, and  
7 Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV,  
8 XXVI, and XXXIIB of the Illinois Insurance Code.

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

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

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

17 (3) a corporation organized under the laws of another  
18 state, 30% or more of the enrollees of which are residents  
19 of this State, except a corporation subject to  
20 substantially the same requirements in its state of  
21 organization as is a "domestic company" under Article VIII  
22 1/2 of the Illinois Insurance Code.

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

26 (1) the Director shall give primary consideration to

1 the continuation of benefits to enrollees and the  
2 financial conditions of the acquired Health Maintenance  
3 Organization after the merger, consolidation, or other  
4 acquisition of control takes effect;

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

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

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

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

24 (C) a pro forma business plan detailing an  
25 acquiring party's plans with respect to the operation  
26 of the Health Maintenance Organization sought to be

1           acquired for a period of not less than 3 years; and

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

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

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

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

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

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

22          The Health Maintenance Organization shall include a  
23          statement in the evidence of coverage issued to each enrollee  
24          describing the possibility of a refund or additional premium,  
25          and upon request of any group or enrollment unit, provide to  
26          the group or enrollment unit a description of the method used

1 to calculate (1) the Health Maintenance Organization's  
2 profitable experience with respect to the group or enrollment  
3 unit and the resulting refund to the group or enrollment unit  
4 or (2) the Health Maintenance Organization's unprofitable  
5 experience with respect to the group or enrollment unit and  
6 the resulting additional premium to be paid by the group or  
7 enrollment unit.

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

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

18 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;  
19 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
20 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,  
21 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;  
22 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.  
23 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,  
24 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;  
25 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.  
26 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,

1 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

2 (215 ILCS 125/5-3.1)

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

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

8 Section 40. The Limited Health Service Organization Act is  
9 amended by changing Sections 4002.1 and 4003 as follows:

10 (215 ILCS 130/4002.1)

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

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

16 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

17 Sec. 4003. Illinois Insurance Code provisions. Limited  
18 health service organizations shall be subject to the  
19 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,  
20 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,  
21 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 355.2,  
22 355.3, 355b, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21,

1 356z.22, 356z.25, 356z.26, 356z.29, ~~356z.30a~~, 356z.32,  
2 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54,  
3 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 364.3,  
4 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444,  
5 and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII  
6 1/2, XXV, and XXVI of the Illinois Insurance Code. Nothing in  
7 this Section shall require a limited health care plan to cover  
8 any service that is not a limited health service. For purposes  
9 of the Illinois Insurance Code, except for Sections 444 and  
10 444.1 and Articles XIII and XIII 1/2, limited health service  
11 organizations in the following categories are deemed to be  
12 domestic companies:

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

14 (2) a corporation organized under the laws of another  
15 state, 30% or more of the enrollees of which are residents  
16 of this State, except a corporation subject to  
17 substantially the same requirements in its state of  
18 organization as is a domestic company under Article VIII  
19 1/2 of the Illinois Insurance Code.

20 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;  
21 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.  
22 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,  
23 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;  
24 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.  
25 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,  
26 eff. 1-1-24; revised 8-29-23.)



1 Section 43. The Voluntary Health Services Plans Act is  
2 amended by changing Section 10 as follows:

3 (215 ILCS 165/10) (from Ch. 32, par. 604)

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

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

1 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;  
2 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff.  
3 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,  
4 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;  
5 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff.  
6 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,  
7 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;  
8 103-551, eff. 8-11-23; revised 8-29-23.)

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

11 (305 ILCS 5/5-16.9)

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

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

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

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

8           Section 99. Effective date. This Act takes effect upon  
9 becoming law, except that the changes to Sections 356r, 356s,  
10 356z.3, and 367a of the Illinois Insurance Code and Section  
11 4.5-1 of the Health Maintenance Organization Act take effect  
12 January 1, 2025."