AN ACT concerning health.

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

Section 5. "An Act concerning regulation", approved January 13, 2023, Public Act 102-1117, is amended by changing Section 99-99 as follows:

(P.A. 102-1117, Sec. 99-99)

Sec. 99-99. Effective date. This Act takes effect upon becoming law, except that Article 16 takes effect on January 1, 2025.

(Source: P.A. 102-1117, eff. 1-13-23.)

Section 10. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

(Text of Section before amendment by P.A. 102-768)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under

Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, ~~and~~ 356z.60, and 356z.62 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

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

(Source: P.A. 101-13, eff. 6-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816,

eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; revised 12-13-22.)

(Text of Section after amendment by P.A. 102-768)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59, ~~and~~ 356z.60, and 356z.62 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance

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

(Source: P.A. 101-13, eff. 6-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-768, eff. 1-1-24; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23.)

Section 15. The Criminal Identification Act is amended by changing Section 3.2 as follows:

(20 ILCS 2630/3.2) (from Ch. 38, par. 206-3.2)

Sec. 3.2. (a) It is the duty of any person conducting or operating a medical facility, or any physician or nurse as soon as treatment permits to notify the local law enforcement agency of that jurisdiction upon the application for treatment of a person who is not accompanied by a law enforcement officer, when it reasonably appears that the person requesting treatment has received:

(1) any injury resulting from the discharge of a firearm; or

(2) any injury sustained in the commission of or as a victim of a criminal offense.

Any hospital, physician or nurse shall be forever held harmless from any civil liability for their reasonable compliance with the provisions of this Section.

(b) Notwithstanding subsection (a), nothing in this Section shall be construed to require the reporting of lawful health care activity, whether such activity may constitute a violation of another state's law.

(c) As used in this Section:

"Lawful health care" means:

(1) reproductive health care that is not unlawful under the laws of this State or was not unlawful under the laws of this State as of January 13, 2023 (the effective date of Public Act 102-1117), including on any theory of vicarious, joint, several, or conspiracy liability; or

(2) the treatment of gender dysphoria or the affirmation of an individual's gender identity or gender expression, including but not limited to, all supplies, care, and services of a medical, behavioral health, mental health, surgical, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, or supportive nature that is not unlawful under the laws of this State or was not unlawful under the laws of this State as of January 13, 2023 (the effective date of Public Act 102-1117), including on any theory of vicarious, joint, several, or

conspiracy liability.

"Lawful health care activity" means seeking, providing, receiving, assisting in seeking, providing, or receiving, providing material support for, or traveling to obtain lawful health care.

(Source: P.A. 102-1117, eff. 1-13-23.)

Section 20. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356q, 356u, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, ~~and~~ 356z.60, and 356z.62 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the

requirements of this Section. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

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

(Source: P.A. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23.)

Section 25. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

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

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

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

(Source: P.A. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23.)

Section 30. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356q, 356u, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, ~~and~~ 356z.60, and 356z.62 of the Illinois Insurance Code. Insurance policies

shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

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

(Source: P.A. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23.)

Section 35. The Illinois Insurance Code is amended by changing Section 356z.4 and by adding Section 356z.62 as follows:

(215 ILCS 5/356z.4)

Sec. 356z.4. Coverage for contraceptives.

(a)(1) The General Assembly hereby finds and declares all of the following:

(A) Illinois has a long history of expanding timely access to birth control to prevent unintended pregnancy.

(B) The federal Patient Protection and Affordable Care Act includes a contraceptive coverage guarantee as part of a broader requirement for health insurance to cover key preventive care services without out-of-pocket costs for patients.

(C) The General Assembly intends to build on existing State and federal law to promote gender equity and women's health and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug Administration approved methods of birth control for all individuals covered by an individual or group health insurance policy in Illinois.

(D) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods.

(2) As used in this subsection (a):

"Contraceptive services" includes consultations, examinations, procedures, and medical services related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

"Medical necessity", for the purposes of this subsection (a), includes, but is not limited to, considerations such as severity of side effects, differences in permanence and

reversibility of contraceptive, and ability to adhere to the appropriate use of the item or service, as determined by the attending provider.

"Therapeutic equivalent version" means drugs, devices, or products that can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling and satisfy the following general criteria:

(i) they are approved as safe and effective;

(ii) they are pharmaceutical equivalents in that they (A) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration and (B) meet compendial or other applicable standards of strength, quality, purity, and identity;

(iii) they are bioequivalent in that (A) they do not present a known or potential bioequivalence problem and they meet an acceptable in vitro standard or (B) if they do present such a known or potential problem, they are shown to meet an appropriate bioequivalence standard;

(iv) they are adequately labeled; and

(v) they are manufactured in compliance with Current Good Manufacturing Practice regulations.

(3) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the effective date of this amendatory Act of the 99th General Assembly shall provide coverage for all of the

following services and contraceptive methods:

(A) All contraceptive drugs, devices, and other products approved by the United States Food and Drug Administration. This includes all over-the-counter contraceptive drugs, devices, and products approved by the United States Food and Drug Administration, excluding male condoms, except as provided in the current comprehensive guidelines supported by the Health Resources and Services Administration. The following apply:

(i) If the United States Food and Drug Administration has approved one or more therapeutic equivalent versions of a contraceptive drug, device, or product, a policy is not required to include all such therapeutic equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this Section.

(ii) If an individual's attending provider recommends a particular service or item approved by the United States Food and Drug Administration based on a determination of medical necessity with respect to that individual, the plan or issuer must cover that service or item without cost sharing. The plan or issuer must defer to the determination of the attending provider.

(iii) If a drug, device, or product is not covered, plans and issuers must have an easily

accessible, transparent, and sufficiently expedient process that is not unduly burdensome on the individual or a provider or other individual acting as a patient's authorized representative to ensure coverage without cost sharing.

(iv) This coverage must provide for the dispensing of 12 months' worth of contraception at one time.

(B) Voluntary sterilization procedures.

(C) Contraceptive services, patient education, and counseling on contraception.

(D) Follow-up services related to the drugs, devices, products, and procedures covered under this Section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(4) Except as otherwise provided in this subsection (a), a policy subject to this subsection (a) shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided. The provisions of this paragraph do not apply to coverage of voluntary male sterilization procedures to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to the federal Internal Revenue Code, 26 U.S.C. 223.

(5) Except as otherwise authorized under this subsection (a), a policy shall not impose any restrictions or delays on

the coverage required under this subsection (a).

(6) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage outlined in this subsection (a), then this subsection (a) is inoperative with respect to all coverage outlined in this subsection (a) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in this subsection (a).

(b) This subsection (b) shall become operative if and only if subsection (a) becomes inoperative.

An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the date this subsection (b) becomes operative that provides coverage for outpatient services and outpatient prescription drugs or devices must provide coverage for the insured and any dependent of the insured covered by the policy for all outpatient contraceptive services and all outpatient contraceptive drugs and devices approved by the Food and Drug

Administration. Coverage required under this Section may not impose any deductible, coinsurance, waiting period, or other cost-sharing or limitation that is greater than that required for any outpatient service or outpatient prescription drug or device otherwise covered by the policy.

Nothing in this subsection (b) shall be construed to require an insurance company to cover services related to permanent sterilization that requires a surgical procedure.

As used in this subsection (b), "outpatient contraceptive service" means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

(c) (Blank).

(d) If a plan or issuer utilizes a network of providers, nothing in this Section shall be construed to require coverage or to prohibit the plan or issuer from imposing cost-sharing for items or services described in this Section that are provided or delivered by an out-of-network provider, unless the plan or issuer does not have in its network a provider who is able to or is willing to provide the applicable items or services.

(Source: P.A. 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19.)

(215 ILCS 5/356z.62 new)

Sec. 356z.62. Coverage of preventive health services.

(a) A policy of group health insurance coverage or individual health insurance coverage as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) of this subsection (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

(b) For purposes of this Section, and for purposes of any other provision of State law, recommendations of the United

States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(c) For office visits:

(1) if an item or service described in subsection (a) is billed separately or is tracked as individual encounter data separately from an office visit, then a policy may impose cost-sharing requirements with respect to the office visit;

(2) if an item or service described in subsection (a) is not billed separately or is not tracked as individual encounter data separately from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a policy may not impose cost-sharing requirements with respect to the office visit; and

(3) if an item or service described in subsection (a) is not billed separately or is not tracked as individual encounter data separately from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a policy may impose cost-sharing requirements with respect to the office visit.

(d) A policy must provide coverage pursuant to subsection (a) for plan or policy years that begin on or after the date that is one year after the date the recommendation or

guideline is issued. If a recommendation or guideline is in effect on the first day of the plan or policy year, the policy shall cover the items and services specified in the recommendation or guideline through the last day of the plan or policy year unless either:

(1) a recommendation under paragraph (1) of subsection (a) is downgraded to a "D" rating; or

(2) the item or service is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during the plan or policy year.

(e) Network limitations.

(1) Subject to paragraph (3) of this subsection, nothing in this Section requires coverage for items or services described in subsection (a) that are delivered by an out-of-network provider under a health maintenance organization health care plan, other than a point-of-service contract, or under a voluntary health services plan that generally excludes coverage for out-of-network services except as otherwise required by law.

(2) Subject to paragraph (3) of this subsection, nothing in this Section precludes a policy with a preferred provider program under Article XX-1/2 of this Code, a health maintenance organization point-of-service contract, or a similarly designed voluntary health

services plan from imposing cost-sharing requirements for items or services described in subsection (a) that are delivered by an out-of-network provider.

(3) If a policy does not have in its network a provider who can provide an item or service described in subsection (a), then the policy must cover the item or service when performed by an out-of-network provider and it may not impose cost-sharing with respect to the item or service.

(f) Nothing in this Section prevents a company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (a) to the extent not specified in the recommendation or guideline.

(g) Nothing in this Section shall be construed to prohibit a policy from providing coverage for items or services in addition to those required under subsection (a) or from denying coverage for items or services that are not required under subsection (a). Unless prohibited by other law, a policy may impose cost-sharing requirements for a treatment not described in subsection (a) even if the treatment results from an item or service described in subsection (a). Nothing in this Section shall be construed to limit coverage requirements provided under other law.

(h) The Director may develop guidelines to permit a company to utilize value-based insurance designs. In the absence of guidelines developed by the Director, any such

guidelines developed by the Secretary of the U.S. Department of Health and Human Services that are in force under 42 U.S.C. 300gg-13 shall apply.

(i) For student health insurance coverage as defined at 45 CFR 147.145, student administrative health fees are not considered cost-sharing requirements with respect to preventive services specified under subsection (a). As used in this subsection, "student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to its students to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

(j) For any recommendation or guideline specifically referring to women or men, a company shall not deny or limit the coverage required or a claim made under subsection (a) based solely on the individual's recorded sex or actual or perceived gender identity, or for the reason that the individual is gender nonconforming, intersex, transgender, or has undergone, or is in the process of undergoing, gender transition, if, notwithstanding the sex or gender assigned at birth, the covered individual meets the conditions for the recommendation or guideline at the time the item or service is furnished.

(k) This Section does not apply to grandfathered health plans, excepted benefits, or short-term, limited-duration

health insurance coverage.

Section 40. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3, 355b, 355c, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356y, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 356z.40, 356z.41, 356z.46, 356z.47, 356z.48, 356z.50, 356z.51, 356z.53 ~~256z.53~~, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.62, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2,

Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

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

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

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

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

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

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

other acquisition of control;

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

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

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

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

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

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

(e) In considering any management contract or service

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

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

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the

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

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

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any

refund authorized under this Section.

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

(Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; revised 1-22-23.)

Section 45. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

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

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,

143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.62, 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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

(Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23.)

Section 50. The Medical Practice Act of 1987 is amended by changing Section 18 as follows:

(225 ILCS 60/18) (from Ch. 111, par. 4400-18)

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

Sec. 18. Visiting professor, physician, or resident permits.

(A) Visiting professor permit.

(1) A visiting professor permit shall entitle a person to practice medicine in all of its branches or to practice the treatment of human ailments without the use of drugs and without operative surgery provided:

(a) the person maintains an equivalent authorization to practice medicine in all of its branches or to practice the treatment of human ailments without the use of drugs and without operative surgery in good standing in his or her native licensing jurisdiction during the period of the visiting professor permit;

(b) the person has received a faculty appointment to teach in a medical, osteopathic or chiropractic school in Illinois; and

(c) the Department may prescribe the information necessary to establish an applicant's eligibility for a permit. This information shall include without limitation (i) a statement from the dean of the

medical school at which the applicant will be employed describing the applicant's qualifications and (ii) a statement from the dean of the medical school listing every affiliated institution in which the applicant will be providing instruction as part of the medical school's education program and justifying any clinical activities at each of the institutions listed by the dean.

(2) Application for visiting professor permits shall be made to the Department, in writing, on forms prescribed by the Department and shall be accompanied by the required fee established by rule, which shall not be refundable. Any application shall require the information as, in the judgment of the Department, will enable the Department to pass on the qualifications of the applicant.

(3) A visiting professor permit shall be valid for no longer than 2 years from the date of issuance or until the time the faculty appointment is terminated, whichever occurs first, and may be renewed only in accordance with subdivision (A)(6) of this Section.

(4) The applicant may be required to appear before the Medical Board for an interview prior to, and as a requirement for, the issuance of the original permit and the renewal.

(5) Persons holding a permit under this Section shall only practice medicine in all of its branches or practice

the treatment of human ailments without the use of drugs and without operative surgery in the State of Illinois in their official capacity under their contract within the medical school itself and any affiliated institution in which the permit holder is providing instruction as part of the medical school's educational program and for which the medical school has assumed direct responsibility.

(6) After the initial renewal of a visiting professor permit, a visiting professor permit shall be valid until the last day of the next physician license renewal period, as set by rule, and may only be renewed for applicants who meet the following requirements:

(i) have obtained the required continuing education hours as set by rule; and

(ii) have paid the fee prescribed for a license under Section 21 of this Act.

For initial renewal, the visiting professor must successfully pass a general competency examination authorized by the Department by rule, unless he or she was issued an initial visiting professor permit on or after January 1, 2007, but prior to July 1, 2007.

(B) Visiting physician permit.

(1) The Department may, in its discretion, issue a temporary visiting physician permit, without examination, provided:

(a) (blank);

(b) that the person maintains an equivalent authorization to practice medicine in all of its branches or to practice the treatment of human ailments without the use of drugs and without operative surgery in good standing in his or her native licensing jurisdiction during the period of the temporary visiting physician permit;

(c) that the person has received an invitation or appointment to study, demonstrate, or perform a specific medical, osteopathic, chiropractic or clinical subject or technique in a medical, osteopathic, or chiropractic school, a state or national medical, osteopathic, or chiropractic professional association or society conference or meeting, a hospital licensed under the Hospital Licensing Act, a hospital organized under the University of Illinois Hospital Act, or a facility operated pursuant to the Ambulatory Surgical Treatment Center Act; and

(d) that the temporary visiting physician permit shall only permit the holder to practice medicine in all of its branches or practice the treatment of human ailments without the use of drugs and without operative surgery within the scope of the medical, osteopathic, chiropractic, or clinical studies, or in

conjunction with the state or national medical, osteopathic, or chiropractic professional association or society conference or meeting, for which the holder was invited or appointed.

(2) The application for the temporary visiting physician permit shall be made to the Department, in writing, on forms prescribed by the Department, and shall be accompanied by the required fee established by rule, which shall not be refundable. The application shall require information that, in the judgment of the Department, will enable the Department to pass on the qualification of the applicant, and the necessity for the granting of a temporary visiting physician permit.

(3) A temporary visiting physician permit shall be valid for no longer than (i) 180 days from the date of issuance or (ii) until the time the medical, osteopathic, chiropractic, or clinical studies are completed, or the state or national medical, osteopathic, or chiropractic professional association or society conference or meeting has concluded, whichever occurs first. The temporary visiting physician permit may be issued multiple times to a visiting physician under this paragraph (3) as long as the total number of days it is active do not exceed 180 days within a 365-day period.

(4) The applicant for a temporary visiting physician permit may be required to appear before the Medical Board

for an interview prior to, and as a requirement for, the issuance of a temporary visiting physician permit.

(5) A limited temporary visiting physician permit shall be issued to a physician licensed in another state who has been requested to perform emergency procedures in Illinois if he or she meets the requirements as established by rule.

(C) Visiting resident permit.

(1) The Department may, in its discretion, issue a temporary visiting resident permit, without examination, provided:

(a) (blank);

(b) that the person maintains an equivalent authorization to practice medicine in all of its branches or to practice the treatment of human ailments without the use of drugs and without operative surgery in good standing in his or her native licensing jurisdiction during the period of the temporary visiting resident permit;

(c) that the applicant is enrolled in a postgraduate clinical training program outside the State of Illinois that is approved by the Department;

(d) that the individual has been invited or appointed for a specific period of time to perform a portion of that post graduate clinical training

program under the supervision of an Illinois licensed physician in an Illinois patient care clinic or facility that is affiliated with the out-of-State post graduate training program; and

(e) that the temporary visiting resident permit shall only permit the holder to practice medicine in all of its branches or practice the treatment of human ailments without the use of drugs and without operative surgery within the scope of the medical, osteopathic, chiropractic or clinical studies for which the holder was invited or appointed.

(2) The application for the temporary visiting resident permit shall be made to the Department, in writing, on forms prescribed by the Department, and shall be accompanied by the required fee established by rule. The application shall require information that, in the judgment of the Department, will enable the Department to pass on the qualifications of the applicant.

(3) A temporary visiting resident permit shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies are completed, whichever occurs first.

(4) The applicant for a temporary visiting resident permit may be required to appear before the Medical Board for an interview prior to, and as a requirement for, the issuance of a temporary visiting resident permit.

(D) Postgraduate training exemption period; visiting rotations. A person may participate in visiting rotations in an approved postgraduate training program, not to exceed a total of 90 days for all rotations, if the following information is submitted in writing or electronically to the Department by the patient care clinics or facilities where the person will be performing the training or by an affiliated program:

(1) The person who has been invited or appointed to perform a portion of their postgraduate clinical training program in Illinois.

(2) The name and address of the primary patient care clinic or facility, the date the training is to begin, and the length of time of the invitation or appointment.

(3) The name and license number of the Illinois physician who will be responsible for supervising the trainee and the medical director or division director of the department or facility.

(4) Certification from the postgraduate training program that the person is approved and enrolled in an graduate training program approved by the Department in their home state.

(Source: P.A. 102-20, eff. 1-1-22.)

Section 95. No acceleration or delay. Where this Act makes

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

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