AN ACT concerning regulation.

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

Section 5. The Uniform Electronic Transactions in Dental Care Billing Act is amended by changing Sections 5, 15, 20, and 25 and by adding Sections 30, 35, and 40 as follows:

(215 ILCS 111/5)

Sec. 5. Purpose. The purpose of this Act is to standardize the forms used in the billing and reimbursement of dental care, reduce the number of forms used, increase efficiency in the reimbursement of dental care through standardization, and encourage the use of and prescribe a timetable for implementation of a secure electronic data interchange of dental care expenses and reimbursement.

(Source: P.A. 102-146, eff. 7-23-21.)

(215 ILCS 111/15)

Sec. 15. Definitions. As used in this Act:

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Dental care provider" means a dentist who bills for services in Illinois.

"Dental plan carrier" means an entity subject to the

insurance laws and regulations of this State or subject to the jurisdiction of the Director that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of dental care services, including an accident and health insurance company, a health maintenance organization, a limited health service organization, a dental service plan corporation, a health services plan corporation, a voluntary health services plan, or any other entity providing a plan of dental insurance, dental benefits, or dental health care services.

"Portal" means a website or reasonably similar method of sharing information that: (i) is compliant with the federal Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder, and (ii) provides resources and information to dental care providers and subscribers.

(Source: P.A. 102-146, eff. 7-23-21.)

(215 ILCS 111/20)

Sec. 20. Uniform electronic claims and eligibility transactions required.

(a) Beginning January 1, 2027 ~~2026~~, no dental plan carrier is required to accept from a dental care provider eligibility for a dental plan transaction or dental care claims or equivalent encounter information transaction except as provided in this Act.

(b) All dental plan carriers and dental care providers must exchange claims and eligibility information electronically using the standard electronic data interchange transactions for claims submissions, payments, and verification of benefits required under the Health Insurance Portability and Accountability Act in order to be compensable by the dental plan carrier.

(c) All dental plan carriers and dental care providers must comply with applicable State and federal privacy and security laws, and regulations when conducting the exchange of information under this Act.

(Source: P.A. 102-146, eff. 7-23-21; 103-705, eff. 7-19-24.)

(215 ILCS 111/25)

Sec. 25. Rules; modification of rules.

(a) The Department may ~~shall~~ adopt rules as necessary to implement this Act and may establish further exemptions to this Act by rule.

(b) A dental plan carrier or dental care provider may not add to or modify the uniform electronic claims and eligibility requirements adopted by the Department.

(Source: P.A. 102-146, eff. 7-23-21.)

(215 ILCS 111/30 new)

Sec. 30. Exemptions.

(a) Notwithstanding any other provision of this Act, a

dental care provider shall not be required to submit claims electronically under any of the following circumstances:

(1) There is a temporary technological event, due to unforeseen practice disruptions, including, but not limited to, natural disasters, physical damage to the practice, or damage to the data system that prevents a claim from being submitted electronically for more than 14 days.

(2) a dental care provider works less than 16 hours per week and is a solo practitioner.

(3) The dental care provider is a dental care provider who is temporarily operating a practice for another dental care provider who is unable to practice.

(b) A dental care provider who is exempted from filing claims electronically under this Section shall file a form with the Department indicating the applicable exemption. The Department shall provide the form no later than January 1, 2027.

(c) Any dental care provider that starts a dental care practice or purchases a practice and who was previously exempted from the requirements of this Act shall have 2 years from the date the practice is started or purchased to comply with this Act.

(215 ILCS 111/35 new)

Sec. 35. Eligibility and benefit verification portal.

(a) Each dental plan carrier shall establish a portal as described in this Section and shall include information about each type of subscription contract that is sufficient to allow subscribers and dental care providers to determine the covered services under each subscription contract and the payment or reimbursement amounts for those covered services at the procedure level. The information in the portal shall include the following, as appropriate:

(1) Effective date of plan.

(2) Termination date of plan.

(3) Coordination of benefits; standard or non-duplicating.

(4) Claim address.

(5) Payer identification.

(6) Covered services.

(7) Whether a deductible applies and to which services.

(8) Remaining deductible: family.

(9) Remaining deductible: individual.

(10) In-network coinsurance percentage.

(11) Out-of-network coinsurance percentage.

(12) Remaining plan maximum.

(13) Remaining lifetime maximum, if applicable.

(14) Previous 12 months of claim payments applied to the member's annual maximum or deductible to help determine if a benefit has been used outside of the

primary office.

(15) Age limitation.

(16) Frequency limit by time period.

(17) Frequency limit by tooth number.

(18) Next available service date or previous service dates based on any frequency limit due to prior treatment history or added custom benefits, such as medical conditions and roll-over.

(19) Number of quads benefited per visit if a specific benefit limitation exists that may limit the number of quads treated and services rendered per visit.

(20) Waiting period due to preexisting condition or missing tooth limitation.

(21) Prior authorization requirements.

(22) A comprehensive list (or procedure code level lookup tool) of all current American Dental Association CDT Codes stating if they are covered, the percentage of coverage, and if there are any conditions that preclude coverage.

(b) At minimum, the portal shall provide current and accurate real-time benefit eligibility and benefits information. It is the responsibility of the dental plan carrier to ensure patient eligibility and benefits reporting is timely and accurate.

(c) A dental plan carrier must ensure that the portal:

(1) is compliant with the federal Health Insurance

Portability and Accountability Act of 1996 and the regulations promulgated thereunder and allows dental care providers to submit claims electronically and directly to the dental plan carrier. The portal shall be provided free of charge to the dental care provider;

(2) accepts attachments, including, but not limited to, x-rays and other supporting information for claims, in an electronic format with the initial electronic claim's submission and any further submissions thereafter; and

(3) offers remittance advice with the corresponding payment that outlines individually per claim: the name of the patient; the date of service; the service code or, if no service code is available, a service description; the amount being paid; the claim number; and other identifying claim information found on an explanation of benefits form.

(215 ILCS 111/40 new)

Sec. 40. Payment. Nothing in this Act requires a dental care provider to only accept electronic payment from a dental plan carrier.

Section 99. Effective date. This Act takes effect upon becoming law, except that Sections 30, 35, and 40 of the Uniform Electronic Transactions in Dental Care Billing Act take effect January 1, 2027.