

1 AN ACT concerning regulation.

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

4 Section 5. The Civil Administrative Code of Illinois is  
5 amended by changing Section 5-235 as follows:

6 (20 ILCS 5/5-235) (was 20 ILCS 5/7.03)

7 Sec. 5-235. In the Department of Public Health.

8 (a) The Director of Public Health shall be either a  
9 physician licensed to practice medicine in all of its branches  
10 in Illinois or a person who has administrative experience in  
11 public health work at the local, state, or national level in  
12 accordance with subsection (b).

13 If the Director is not a physician licensed to practice  
14 medicine in all its branches, then a Medical Director shall be  
15 appointed who shall be a physician licensed to practice  
16 medicine in all its branches. The Medical Director shall  
17 report directly to the Director. If the Director is not a  
18 physician, the Medical Director shall have primary  
19 responsibility for overseeing the following regulatory and  
20 policy areas:

21 (1) Department responsibilities concerning hospital  
22 and health care facility regulation, emergency services,  
23 ambulatory surgical treatment centers, health care

1 professional regulation and credentialing, advising the  
2 Board of Health, patient safety initiatives, and the  
3 State's response to disease prevention and outbreak  
4 management and control.

5 (2) Advising the Director on the control of diseases  
6 for which an immunization is licensed by the United States  
7 Food and Drug Administration. The advice may include  
8 guidance for the use of immunizations or medical  
9 countermeasures based on medical and scientific evidence,  
10 if circumstances warrant. The Medical Director may issue  
11 guidance and recommendations on immunizations or medical  
12 countermeasures in the absence of such recommendations  
13 from the Director or to further supplement recommendations  
14 as necessary.

15 (3) ~~(2)~~ Any other duties assigned by the Director or  
16 required by law.

17 (b) A Director of Public Health who is not a physician  
18 licensed to practice medicine in all its branches shall at a  
19 minimum have the following education and experience:

20 (1) 5 years of full-time administrative experience in  
21 public health and a master's degree in public health from  
22 (i) a college or university accredited by the North  
23 Central Association or (ii) any other nationally  
24 recognized regional accrediting agency; or

25 (2) 5 years of full-time administrative experience in  
26 public health and a graduate degree in a related field

1 from (i) a college or university accredited by the North  
2 Central Association or (ii) any other nationally  
3 recognized regional accrediting agency. For the purposes  
4 of this item (2), "a graduate degree in a related field"  
5 includes, but is not limited to, a master's degree in  
6 public administration, nursing, environmental health,  
7 community health, or health education.

8 (c) The Assistant Director of Public Health shall be a  
9 person who has administrative experience in public health  
10 work.

11 (Source: P.A. 97-798, eff. 7-13-12.)

12 Section 10. The Department of Commerce and Economic  
13 Opportunity Law of the Civil Administrative Code of Illinois  
14 is amended by changing Section 605-60 and adding Section  
15 605-70 as follows:

16 (20 ILCS 605/605-60)

17 (Text of Section before amendment by P.A. 104-27)

18 Sec. 605-60. DCEO Projects Fund. The DCEO Projects Fund is  
19 created as a trust fund in the State treasury. The Department  
20 is authorized to accept and deposit into the Fund moneys  
21 received from any gifts, grants, transfers, or other sources,  
22 public or private, unless deposit into a different fund is  
23 otherwise mandated. Subject to appropriation, the Department  
24 shall use moneys in the Fund to make grants or loans to and

1 enter into contracts with units of local government, local and  
2 regional economic development corporations, and not-for-profit  
3 organizations for municipal development projects, for the  
4 specific purposes established by the terms and conditions of  
5 the gift, grant, or award, and for related administrative  
6 expenses. As used in this Section, the term "municipal  
7 development projects" includes, but is not limited to, grants  
8 for reducing food insecurity in urban and rural areas.

9 (Source: P.A. 103-588, eff. 6-5-24.)

10 (Text of Section after amendment by P.A. 104-27)

11 Sec. 605-60. DCEO Projects Fund.

12 (a) The DCEO Projects Fund is created as a trust fund in  
13 the State treasury. The Department is authorized to accept and  
14 deposit into the Fund moneys received from any gifts, grants,  
15 transfers, or other sources, public or private, unless deposit  
16 into a different fund is otherwise mandated.

17 (b) Subject to appropriation, the Department shall use  
18 moneys in the Fund to make grants or loans to and enter into  
19 contracts with units of local government, local and regional  
20 economic development corporations, retail associations, and  
21 not-for-profit organizations for municipal development  
22 projects, for the specific purposes established by the terms  
23 and conditions of the gift, grant, or award, and for related  
24 administrative expenses. As used in this Section, the term  
25 "municipal development projects" includes, but is not limited

1 to, grants for reducing food insecurity in urban and rural  
2 areas.

3 ~~(c) In this subsection, "rural tract" and "urban tract"~~  
4 ~~have the meanings given to those terms in Section 5 of the~~  
5 ~~Grocery Initiative Act.~~

6 ~~Subject to appropriation, the Department shall use moneys~~  
7 ~~deposited into the Fund pursuant to Section 513b2 of the~~  
8 ~~Illinois Insurance Code to make a grant to a statewide retail~~  
9 ~~association representing pharmacies to promote access to~~  
10 ~~pharmacies and pharmacist services. Grant funds under this~~  
11 ~~subsection shall be made available to the following~~  
12 ~~beneficiaries:-~~

13 ~~(1) critical access care pharmacies as defined in~~  
14 ~~Section 5-5.12b of the Illinois Public Aid Code;~~

15 ~~(2) retail pharmacies with a physical location in~~  
16 ~~Illinois owned by a person or entity with an ownership or~~  
17 ~~control interest in fewer than 10 pharmacies;~~

18 ~~(3) retail pharmacies with a physical location in a~~  
19 ~~county in Illinois with fewer than 50,000 residents;~~

20 ~~(4) retail pharmacies with a physical location in a~~  
21 ~~county in Illinois with 50,000 or more residents and in an~~  
22 ~~area within Illinois that is designated by the United~~  
23 ~~States Department of Health and Human Services as either:-~~

24 ~~(A) a Medically Underserved Area, including Governor's~~  
25 ~~Exceptions; or (B) a Medically Underserved Population,~~  
26 ~~including Governor's Exceptions;~~

~~(5) pharmacies whose claims constitute 65% or greater for Medicaid services and at least 80% of their total claims are for pharmacy services administered in Illinois;~~

~~(6) a pharmacy located in an Illinois census tract that meets both of the following poverty and population density and pharmacy accessibility standards:~~

~~(A) the census tract has either: (i) 20% or more of its population living below the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2); or (ii) a median household income of less than 80% of the median income of the nearest metropolitan area; and~~

~~(B) the census tract has at least 33% of its population living one mile or more from the pharmacy for urban tracts or more than 10 miles from the pharmacy for rural tracts.~~

~~At least annually, the Department shall file with the Governor and the General Assembly a report that includes:~~

~~(1) the number of beneficiaries who applied for funding;~~

~~(2) the number of beneficiaries who received funding; and~~

~~(3) the pharmacies that were awarded funding, including the location, the amount of funding, and the subsection category or categories under which the pharmacy~~

1 ~~qualified.~~

2 (Source: P.A. 103-588, eff. 6-5-24; 104-27, eff. 1-1-26.)

3 (20 ILCS 605/605-70 new)

4 Sec. 605-70. Pharmacy support program.

5 (a) Subject to appropriation, the Department shall use  
6 moneys deposited into the DCEO Projects Fund pursuant to  
7 Section 513b2 of the Illinois Insurance Code to make a grant to  
8 a statewide retail association representing pharmacies to  
9 promote access to pharmacies and pharmacist services.

10 (b) Grant funds under subsection (a) shall be made  
11 available to the following beneficiaries:

12 (1) critical access care pharmacies as defined in  
13 Section 5-5.12b of the Illinois Public Aid Code;

14 (2) retail pharmacies with a physical location in  
15 Illinois owned by a person or entity with an ownership or  
16 control interest in fewer than 10 pharmacies;

17 (3) retail pharmacies with a physical location in a  
18 county in Illinois with fewer than 50,000 residents;

19 (4) retail pharmacies with a physical location in a  
20 county in Illinois with 50,000 or more residents and in an  
21 area within Illinois that is designated by the United  
22 States Department of Health and Human Services as either:

23 (A) a Medically Underserved Area, including  
24 Governor's Exceptions; or

25 (B) a Medically Underserved Population, including

1           Governor's Exceptions;

2           (5) pharmacies whose claims constitute 65% or greater  
3           for Medicaid services and at least 80% of their total  
4           claims are for pharmacy services administered in Illinois;

5           (6) a pharmacy located in an Illinois census tract  
6           that meets both of the following poverty and population  
7           density and pharmacy accessibility standards:

8                 (A) the census tract has either: (i) 20% or more of  
9                 its population living below the poverty guidelines  
10                updated periodically in the Federal Register by the  
11                U.S. Department of Health and Human Services under the  
12                authority of 42 U.S.C. 9902(2); or (ii) a median  
13                household income of less than 80% of the median income  
14                of the nearest metropolitan area; and

15                (B) the census tract has at least 33% of its  
16                population living one mile or more from the pharmacy  
17                for urban tracts or more than 10 miles from the  
18                pharmacy for rural tracts.

19           (c) In subsection (b), "rural tract" and "urban tract"  
20           have the meanings given to those terms in Section 5 of the  
21           Grocery Initiative Act.

22           (d) Grant funds under subsection (a) shall be disbursed in  
23           equal amounts to each beneficiary eligible under subsection  
24           (b) that applies for an award. To determine the equal amount  
25           available for each beneficiary eligible under subsection (b)  
26           each State fiscal year, the total amount appropriated from the



1 DCEO Projects Fund using moneys deposited under Section 513b2  
2 of the Illinois Insurance Code less any amount provided to a  
3 statewide retail association for administrative expenses shall  
4 be divided by the total number of nonduplicate beneficiaries  
5 eligible under subsection (b) that apply for an award in the  
6 same fiscal year. A beneficiary may only receive one award per  
7 fiscal year even if the beneficiary may qualify under multiple  
8 beneficiary categories in subsection (b).

9 (e) At least annually, the Department shall file with the  
10 Governor and the General Assembly a report on the  
11 implementation of subsections (a) through (d) that includes:

12 (1) the number of beneficiaries who applied for  
13 funding;

14 (2) the number of beneficiaries who received funding;  
15 and

16 (3) the pharmacies that were awarded funding,  
17 including the location, the amount of funding, and the  
18 subsection (b) category or categories under which the  
19 pharmacy qualified.

20 Section 15. The Department of Public Health Act is amended  
21 by changing Section 8.4 as follows:

22 (20 ILCS 2305/8.4)

23 Sec. 8.4. Immunization Advisory Committee.

24 (a) Definitions. For the purposes of this Section:

1 "Committee" means the Immunization Advisory Committee.

2 "Immunization" means the treatment of an individual with  
3 any vaccine or immunologic drug licensed, approved, or  
4 authorized for use by the United States Food and Drug  
5 Administration, including emergency use authorization agents,  
6 or meeting World Health Organization requirements, and  
7 designed for the purpose of producing or enhancing an immune  
8 response against a vaccine-preventable disease.

9 "Medical countermeasures" means products regulated by the  
10 United States Food and Drug Administration that may be used in  
11 a public health emergency, stemming from a terrorist attack or  
12 accidental release of a biological, chemical, or  
13 radiological/nuclear agent or a naturally occurring emerging  
14 infectious disease.

15 (b) The Director of Public Health shall appoint an  
16 Immunization Advisory Committee to advise the Director on  
17 immunization issues, including:

18 (1) The control of diseases for which an immunization  
19 or medical countermeasure is licensed or regulated in the  
20 United States by the United States Food and Drug  
21 Administration. The advice shall address the use of  
22 immunizations or medical countermeasures shown to be  
23 effective in controlling a disease for which an  
24 immunization is available. Advice for the use of  
25 unlicensed but regulated immunizations or medical  
26 countermeasures may be provided based on medical and

1       scientific evidence, if circumstances warrant. For each  
2       immunization or medical countermeasure, the Committee  
3       shall advise on population groups or circumstances in  
4       which it is recommended. The Committee shall also provide  
5       recommendations on contraindications and precautions for  
6       the use of the immunization or medical countermeasures and  
7       provide information on recognized adverse events. The  
8       Committee may provide recommendations that address the  
9       general use of immunizations or medical countermeasures  
10       and special situations or populations that may warrant  
11       modification of the routine recommendations.

12       (2) The use of immunizations or medical  
13       countermeasures to control disease in Illinois, which  
14       shall include consideration of disease epidemiology and  
15       burden of disease, immunization or medical countermeasure  
16       safety, immunization or medical countermeasure efficacy  
17       and effectiveness, the quality of evidence reviewed,  
18       economic analyses, and implementation issues. The  
19       Committee may revise or withdraw its recommendations  
20       regarding a particular immunization or medical  
21       countermeasure as new information on disease epidemiology,  
22       vaccine effectiveness or safety, economic considerations,  
23       or other data become available.

24       (3) The Department of Public Health shall publish any  
25       recommendations issued by the Immunization Advisory  
26       Committee on the Department's website.

1        (c) The Director shall take into consideration any  
2        comments or recommendations made by the Immunization Advisory  
3        Committee.

4        (d) The Immunization Advisory Committee shall be composed  
5        of no more than 21 ~~the following~~ members with knowledge of  
6        immunization issues. Members shall serve for terms totaling 6  
7        years for a maximum of 2 terms. On the effective date of this  
8        amendatory Act of the 104th General Assembly, existing members  
9        and any members appointed after the effective date of this  
10       amendatory Act of the 104th General Assembly shall be assigned  
11       equally into one of 3 classes. Members of the first class shall  
12       vacate their seats after 2 years; the second class shall  
13       vacate their seats after 4 years; and the third class shall  
14       vacate their seats after 6 years so that one-third of members  
15       may be appointed every 2 years. Any members serving on the  
16       effective date of this amendatory Act of the 104th General  
17       Assembly shall continue as members for whatever remainder of  
18       time left for the class they are assigned until the completion  
19       of that class's term. Members serving on the effective date of  
20       this amendatory Act of the 104th General Assembly may serve 2  
21       terms after their current term expires.

22       Members of the Immunization Advisory Committee appointed  
23       after the effective date of this amendatory Act of the 104th  
24       General Assembly shall include: (i) the Medical Director of  
25       the Department of Public Health or the Medical Director's  
26       delegate, (ii) a representative from an Illinois local health

1 department, (iii) a certified school nurse or a registered  
2 nurse working in a public school, (iv) a public health officer  
3 or administrator, (v) a representative of an immunization  
4 advocacy organization, (vi) a representative from the State  
5 Board of Education, and (vii) licensed health care  
6 professionals with knowledge of immunization issues in good  
7 standing with the Department of Financial and Professional  
8 Regulation, including, but not limited to, a pediatrician, a  
9 family physician, an internal medicine physician, an  
10 obstetrician-gynecologist, a pharmacist, an academic  
11 infectious disease clinician, a public health medical  
12 provider, and at least one registered nurse. Physician members  
13 must be licensed to practice medicine in all its branches. The  
14 Department of Public Health may adopt rules and bylaws, as  
15 necessary, on membership eligibility, voting procedures, and  
16 other administrative matters for the Immunization Advisory  
17 Committee in accordance with the Illinois Administrative  
18 Procedure Act and any other applicable laws: a pediatrician, a  
19 physician licensed to practice medicine in all its branches, a  
20 family physician, an infectious disease specialist from a  
21 university based center, 2 representatives of a local health  
22 department, a registered nurse, a school nurse, a public  
23 health provider, a public health officer or administrator, a  
24 representative of a children's hospital, 2 representatives of  
25 immunization advocacy organizations, a representative from the  
26 State Board of Education, a person with expertise in

1 ~~bioterrorism issues, and any other individuals or organization~~  
2 ~~representatives designated by the Director.~~ The Director shall  
3 designate one of the Advisory Committee members with a degree  
4 of doctor of medicine or doctor of osteopathy to serve as the  
5 Chairperson of the Advisory Committee.

6 (e) If, in the opinion of the Chairperson of the  
7 Immunization Advisory Committee, the Director of Public Health  
8 does not adequately consider the recommendations of the  
9 Immunization Advisory Committee in issuing the State  
10 Guidelines for Communicable Disease Prevention pursuant to  
11 Section 1.2 of the Communicable Disease Prevention Act, the  
12 Chairperson may call for an override vote. If two-thirds of  
13 the Immunization Advisory Committee vote to override the  
14 Director's published State Guidelines for Communicable Disease  
15 Prevention, the Immunization Advisory Committee may republish  
16 recommendations to serve as the State Guidelines for  
17 Communicable Disease Prevention. These recommendations shall  
18 serve as the State Guidelines for Communicable Disease  
19 Prevention for not less than 6 months.

20 (Source: P.A. 92-561, eff. 6-24-02.)

21 Section 20. The Illinois Insurance Code is amended by  
22 changing Sections 356z.62, 356z.77, and 424 as follows:

23 (215 ILCS 5/356z.62)

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

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

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

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

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

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

25 (5) immunizations and medical countermeasures that  
26 have in effect a recommendation within the State

Guidelines for Communicable Disease Prevention issued by the Director of Public Health pursuant to Section 1.2 of the Communicable Disease Prevention Act, with respect to the individual involved. For this paragraph, the prohibition on cost-sharing requirements does not apply if and to the extent that the coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code.

(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



1 visit; and

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

9 (d) A policy must provide coverage pursuant to subsection  
10 (a) for plan or policy years that begin on or after the date  
11 that is one year after the date the recommendation or  
12 guideline is issued. If a recommendation or guideline is in  
13 effect on the first day of the plan or policy year, or if a  
14 recommendation becomes effective for an in-force policy under  
15 the circumstances described in subsection (d-5), the policy  
16 shall cover the items and services specified in the  
17 recommendation or guideline through the last day of the plan  
18 or policy year unless either:

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

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

25 (d-5) Notwithstanding subsection (d), a policy, including  
26 an in-force policy, must provide coverage pursuant to

1 paragraph (5) of subsection (a) within 15 business days after  
2 the date the State Guidelines for Communicable Disease  
3 Prevention are issued if the Guidelines reinstate any  
4 recommendation or portion thereof under paragraph (2) of  
5 subsection (a) that the Advisory Committee on Immunization  
6 Practices has reduced or withdrawn.

7 (e) Network limitations.

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

17 (2) Subject to paragraph (3) of this subsection,  
18 nothing in this Section precludes a policy with a  
19 preferred provider program under Article XX-1/2 of this  
20 Code, a health maintenance organization point-of-service  
21 contract, or a similarly designed voluntary health  
22 services plan from imposing cost-sharing requirements for  
23 items or services described in subsection (a) that are  
24 delivered by an out-of-network provider.

25 (3) If a policy does not have in its network a provider  
26 who can provide an item or service described in subsection

1 (a), then the policy must cover the item or service when  
2 performed by an out-of-network provider and it may not  
3 impose cost-sharing with respect to the item or service.

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

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

19 (h) The Director may develop guidelines to permit a  
20 company to utilize value-based insurance designs. In the  
21 absence of guidelines developed by the Director, any such  
22 guidelines developed by the Secretary of the U.S. Department  
23 of Health and Human Services that are in force under 42 U.S.C.  
24 300gg-13 shall apply.

25 (i) For student health insurance coverage as defined at 45  
26 CFR 147.145, student administrative health fees are not

1 considered cost-sharing requirements with respect to  
2 preventive services specified under subsection (a). As used in  
3 this subsection, "student administrative health fee" means a  
4 fee charged by an institution of higher education on a  
5 periodic basis to its students to offset the cost of providing  
6 health care through health clinics regardless of whether the  
7 students utilize the health clinics or enroll in student  
8 health insurance coverage.

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

20 (k) This Section does not apply to grandfathered health  
21 plans, excepted benefits, or short-term, limited-duration  
22 health insurance coverage.

23 (Source: P.A. 103-551, eff. 8-11-23.)

24 (215 ILCS 5/356z.77)

25 Sec. 356z.77 ~~356z.71~~. Coverage of vaccination

1 administration fees.

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, 2026 shall provide  
5 coverage for vaccinations for COVID-19, influenza, and  
6 respiratory syncytial virus, including the administration of  
7 the vaccine by a pharmacist or health care provider authorized  
8 to administer such a vaccine, without imposing a deductible,  
9 coinsurance, copayment, or any other cost-sharing requirement,  
10 if the following conditions are met:

11 (1) the vaccine is authorized or licensed by the  
12 United States Food and Drug Administration; and

13 (2) the vaccine is ordered and administered according  
14 to the State Guidelines for Communicable Disease  
15 Prevention issued by the Director of Public Health  
16 pursuant to Section 1.2 of the Communicable Disease  
17 Prevention Act or the Advisory Committee on Immunization  
18 Practices standard immunization schedule.

19 (b) If the vaccinations provided for in subsection (a) are  
20 not otherwise available to be administered by a contracted  
21 pharmacist or health care provider, the group or individual  
22 policy of accident and health insurance or a managed care plan  
23 shall cover the vaccination, including administration fees,  
24 without imposing a deductible, coinsurance, copayment, or any  
25 other cost-sharing requirement.

26 (c) The coverage required in this Section does not apply

1 to the extent that the coverage would disqualify a  
2 high-deductible health plan from eligibility for a health  
3 savings account pursuant to Section 223 of the Internal  
4 Revenue Code of 1986.

5 (Source: P.A. 103-918, eff. 1-1-25; revised 12-3-24.)

6 (215 ILCS 5/424) (from Ch. 73, par. 1031)

7 (Text of Section before amendment by P.A. 104-55)

8 Sec. 424. Unfair methods of competition and unfair or  
9 deceptive acts or practices defined. The following are hereby  
10 defined as unfair methods of competition and unfair and  
11 deceptive acts or practices in the business of insurance:

12 (1) The commission by any person of any one or more of  
13 the acts defined or prohibited by Sections 134, 143.24c,  
14 147, 148, 149, 151, 155.22, 155.22a, 155.42, 236, 237,  
15 364, 469, and 513b1 of this Code.

16 (2) Entering into any agreement to commit, or by any  
17 concerted action committing, any act of boycott, coercion  
18 or intimidation resulting in or tending to result in  
19 unreasonable restraint of, or monopoly in, the business of  
20 insurance.

21 (3) Making or permitting, in the case of insurance of  
22 the types enumerated in Classes 1, 2, and 3 of Section 4,  
23 any unfair discrimination between individuals or risks of  
24 the same class or of essentially the same hazard and  
25 expense element because of the race, color, religion, or

1 national origin of such insurance risks or applicants. The  
2 application of this Article to the types of insurance  
3 enumerated in Class 1 of Section 4 shall in no way limit,  
4 reduce, or impair the protections and remedies already  
5 provided for by Sections 236 and 364 of this Code or any  
6 other provision of this Code.

7 (4) Engaging in any of the acts or practices defined  
8 in or prohibited by Sections 154.5 through 154.8 of this  
9 Code.

10 (5) Making or charging any rate for insurance against  
11 losses arising from the use or ownership of a motor  
12 vehicle which requires a higher premium of any person by  
13 reason of his physical disability, race, color, religion,  
14 or national origin.

15 (6) Failing to meet any requirement of the Unclaimed  
16 Life Insurance Benefits Act with such frequency as to  
17 constitute a general business practice.

18 (Source: P.A. 102-778, eff. 7-1-22.)

19 (Text of Section after amendment by P.A. 104-55)

20 Sec. 424. Unfair methods of competition and unfair or  
21 deceptive acts or practices defined. The following are hereby  
22 defined as unfair methods of competition and unfair and  
23 deceptive acts or practices in the business of insurance:

24 (1) The commission by any person of any one or more of  
25 the acts defined or prohibited by Sections 134, 143.24c,

1 147, 148, 149, 151, 155.22, 155.22a, 155.42, 236, 237,  
2 364, 469, and 513b1 of this Code.

3 (2) Entering into any agreement to commit, or by any  
4 concerted action committing, any act of boycott, coercion  
5 or intimidation resulting in or tending to result in  
6 unreasonable restraint of, or monopoly in, the business of  
7 insurance.

8 (3) Making or permitting, in the case of insurance of  
9 the types enumerated in Classes 1, 2, and 3 of Section 4,  
10 any unfair discrimination between individuals or risks of  
11 the same class or of essentially the same hazard and  
12 expense element because of the race, color, religion, or  
13 national origin of such insurance risks or applicants. The  
14 application of this Article to the types of insurance  
15 enumerated in Class 1 of Section 4 shall in no way limit,  
16 reduce, or impair the protections and remedies already  
17 provided for by Sections 236 and 364 of this Code or any  
18 other provision of this Code.

19 (4) Engaging in any of the acts or practices defined  
20 in or prohibited by Sections 154.5 through 154.8 of this  
21 Code.

22 (5) Making or charging any rate for insurance against  
23 losses arising from the use or ownership of a motor  
24 vehicle which requires a higher premium of any person by  
25 reason of his physical disability, race, color, religion,  
26 or national origin.



1           (6) Failing to meet any requirement of the Unclaimed  
2 Life Insurance Benefits Act with such frequency as to  
3 constitute a general business practice.

4           (7) Soliciting either an individual who is a resident  
5 of a nursing home or long-term care facility or an  
6 individual who is over the age of 65, as described in  
7 paragraph (8) of this Section, to purchase accident or  
8 health insurance, unless the person who is selling the  
9 insurance:

10           (A) advises the potential enrollee of the benefit  
11 of examining the potential enrollee's current  
12 insurance plan, discusses all proposed  
13 insurance-related changes with a family member,  
14 friend, or other advisor of the potential enrollee,  
15 and then waits 48 hours before making any  
16 insurance-related changes concerning the potential  
17 enrollee;

18           (B) provides a phone number that may be called if  
19 the potential enrollee or the potential enrollee's  
20 family members, friends, or other advisors have any  
21 questions; and

22           (C) allows the potential enrollee to opt out of  
23 any future communications with the person.

24           (8) Entering into or amending an accident or health  
25 insurance policy with an individual who is over the age of  
26 65 and who has executed a health care power of attorney or

1 has a medical condition, such as dementia, that reduces  
2 the person's capacity to make informed decisions  
3 independently, unless the potential enrollee's agent under  
4 a health care power of attorney executes the agreement and  
5 the agreement is reduced to writing.

6 (Source: P.A. 104-55, eff. 1-1-26.)

7 Section 25. The Illinois Insurance Code is amended by  
8 changing Section 513b1, 513b1.1, and 513b2 as follows:

9 (215 ILCS 5/513b1)

10 (Text of Section before amendment by P.A. 104-27)

11 Sec. 513b1. Pharmacy benefit manager contracts.

12 (a) As used in this Article ~~Section~~:

13 "340B drug discount program" means the program established  
14 under Section 340B of the federal Public Health Service Act,  
15 42 U.S.C. 256b.

16 "340B entity" means a covered entity as defined in 42  
17 U.S.C. 256b(a)(4) authorized to participate in the 340B drug  
18 discount program.

19 "340B pharmacy" means any pharmacy used to dispense 340B  
20 drugs for a covered entity, whether entity-owned or external.

21 "Affiliate" means a person or entity that directly or  
22 indirectly through one or more intermediaries controls or is  
23 controlled by, or is under common control with, the person or  
24 entity specified. The location of a person or entity's

1 domicile, whether in Illinois or a foreign or alien  
2 jurisdiction, does not affect the person or entity's status as  
3 an affiliate.

4 "Biological product" has the meaning ascribed to that term  
5 in Section 19.5 of the Pharmacy Practice Act.

6 "Brand name drug" means a drug that has been approved  
7 under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is  
8 marketed, sold, or distributed under a proprietary,  
9 trademark-protected name.

10 "Complex or chronic medical condition" means a physical,  
11 behavioral, or developmental condition that has no known cure,  
12 is progressive, or can be debilitating or fatal if unmanaged  
13 or untreated.

14 "Covered individual" means a member, participant,  
15 enrollee, contract holder, policyholder, or beneficiary of a  
16 health benefit plan who is provided a drug benefit by the  
17 health benefit plan.

18 "Critical access pharmacy" means a critical access care  
19 pharmacy as defined in Section 5-5.12b of the Illinois Public  
20 Aid Code.

21 "Drugs" has the meaning ascribed to that term in Section 3  
22 of the Pharmacy Practice Act and includes biological products.

23 "Employee welfare benefit plan" has the meaning given to  
24 that term in 29 U.S.C. 1002(1), without regard for whether the  
25 employee welfare benefit plan is covered under 29 U.S.C. 1003.

26 "Federal governmental plan" has the meaning given to that

1 term in 42 U.S.C. 300gg-91(d)(8)(B).

2 "Generic drug" means a drug that has been approved under  
3 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is  
4 marketed, sold, or distributed directly or indirectly to the  
5 retail class of trade with labeling, packaging (other than  
6 repackaging as the listed drug in blister packs, unit doses,  
7 or similar packaging for use in institutions), product code,  
8 labeler code, trade name, or trademark that differs from that  
9 of the brand name drug.

10 "Health benefit plan" means a policy, contract,  
11 certificate, or agreement entered into, offered, or issued by  
12 an insurer to provide, deliver, arrange for, pay for, or  
13 reimburse any of the costs of physical, mental, or behavioral  
14 health care services. Notwithstanding Sections 122-1 through  
15 122-4 of this Code, "health benefit plan" includes self-funded  
16 employee welfare benefit plans except for self-funded  
17 multiemployer plans that are not nonfederal government plans.

18 "Health benefit plan" does not include:

19 (1) workers compensation insurance, a federal  
20 governmental plan, Medicare Advantage, Medicare Part D, a  
21 Medicare demonstration program, or Tricare; or

22 (2) any program for dually eligible Medicare-Medicaid  
23 beneficiaries enrolled in a program under which Medicare  
24 pays for most or all of the covered drugs.

25 "Health benefit plan sponsor" or "plan sponsor" means:

26 (1) a plan sponsor, as defined in 29 U.S.C.

1       1002(16)(B), without regard for whether the employee  
2       welfare benefit plan is covered under 29 U.S.C. 1003.  
3       Except as provided by subsection (m), "plan sponsor"  
4       includes the plan sponsor of a nonfederal governmental  
5       plan, including a joint insurance pool described in  
6       Section 6 of the Intergovernmental Cooperation Act; and  
7       (2) any other governmental unit or public agency to  
8       which any State law grants the rights of a plan sponsor  
9       when incorporating this Article by reference.

10       "Maximum allowable cost" means the maximum amount that a  
11       pharmacy benefit manager will reimburse a pharmacy for the  
12       cost of a drug.

13       "Maximum allowable cost list" means a list of drugs for  
14       which a maximum allowable cost has been established by a  
15       pharmacy benefit manager.

16       "Multiemployer plan" has the meaning given to that term in  
17       29 U.S.C. 1002(37).

18       "Nonfederal governmental plan" has the meaning given to  
19       that term in 42 U.S.C. 300gg-91(d)(8)(C).

20       "Pharmacy benefit manager" means a person, business, or  
21       entity, including a wholly or partially owned or controlled  
22       subsidiary of a pharmacy benefit manager, that provides claims  
23       processing services or other ~~prescription~~ drug or device  
24       services, or both, for health benefit plans.

25       "Pharmacy" has the meaning given to that term in Section 3  
26       of the Pharmacy Practice Act.

1       "Pharmacy services" means the provision of any services  
2       listed within the definition of "practice of pharmacy" under  
3       subsection (d) of Section 3 of the Pharmacy Practice Act.

4       "Rare medical condition" means a physical, behavioral, or  
5       developmental condition that affects fewer than 200,000  
6       individuals in the United States or approximately 1 in 1,500  
7       individuals worldwide.

8       "Rebate" means a discount or pricing concession based on  
9       drug utilization or administration that is paid by the  
10       manufacturer to a pharmacy benefit manager or its client.

11       "Rebate aggregator" means a person or entity, including  
12       group purchasing organizations, that negotiate rebates or  
13       other fees with drug manufacturers on behalf or for the  
14       benefit of a pharmacy benefit manager or its client and may  
15       also be involved in contracts that entitle the rebate  
16       aggregator or its client to receive rebates or other fees from  
17       drug manufacturers based on drug utilization or  
18       administration.

19       "Retail price" means the price an individual without  
20       ~~prescription~~ drug coverage would pay at a retail pharmacy, not  
21       including a pharmacist dispensing fee.

22       "Specialty drug" means a drug that:

23               (1) is prescribed for a person with a complex or  
24               chronic medical condition or a rare medical condition;

25               (2) has limited or exclusive distribution; and

26               (3) requires both:

1           (A) specialized product handling by the dispensing  
2           pharmacy or administration by the dispensing pharmacy;  
3           and

4           (B) specialized clinical care, including frequent  
5           dosing adjustments, intensive clinical monitoring, or  
6           expanded services for patients, including intensive  
7           patient counseling, education, or ongoing clinical  
8           support beyond traditional dispensing activities, such  
9           as individualized disease and therapy management to  
10          support improved health outcomes.

11          "Spread pricing" means the model of drug pricing in which  
12          the pharmacy benefit manager charges a health benefit plan a  
13          contracted price for drugs, and the contracted price for the  
14          drugs differs from the amount the pharmacy benefit manager  
15          directly or indirectly pays the pharmacist or pharmacy for the  
16          drugs, pharmacist services, or drug and dispensing fees.

17          "Steer" includes, but is not limited to:

18           (1) requiring a covered individual to only use a  
19           pharmacy, including a mail-order or specialty pharmacy, in  
20           which the pharmacy benefit manager or its affiliate, or an  
21           insurer or its affiliate, maintains an ownership interest  
22           or control;

23           (2) offering or implementing a plan design that  
24           encourages a covered individual to only use a pharmacy in  
25           which the pharmacy benefit manager or an affiliate, or an  
26           insurer or its affiliate, maintains an ownership interest

1 or control, if the plan design increases costs for the  
2 covered individual. This includes a plan design that  
3 requires a covered individual to pay higher costs or an  
4 increased share of costs for a drug or drug-related  
5 service if the covered individual uses a pharmacy that is  
6 not owned or controlled by the pharmacy benefit manager or  
7 its affiliate or an insurer or its affiliate; and

8 (3) reimbursing a pharmacy or pharmacist for a drug  
9 and pharmacist service in an amount less than the amount  
10 that the pharmacy benefit manager or an insurer reimburses  
11 itself or an affiliate, including affiliated manufacturers  
12 or joint ventures for providing the same drug or service.

13 "Third-party payer" means any entity that pays for  
14 ~~prescription~~ drugs on behalf of a patient other than a health  
15 care provider or sponsor of a plan subject to regulation under  
16 Medicare Part D, 42 U.S.C. 1395w-101 et seq.

17 The changes made to this subsection by this amendatory Act  
18 of the 104th General Assembly shall be deemed to be operative  
19 on and after July 1, 2025.

20 (a-5) In this Article, references to an "insurer" or  
21 "health insurer" shall include commercial private health  
22 insurance issuers, managed care organizations, managed care  
23 community networks, and any other third-party payer that  
24 contracts with pharmacy benefit managers or with the  
25 Department of Healthcare and Family Services to provide  
26 benefits or services under the Medicaid program or to



1 otherwise engage in the administration or payment of pharmacy  
2 benefits. However, the terms do not refer to the plan sponsor  
3 of a self-funded, single-employer employee welfare benefit  
4 plan or self-funded multiemployer plan if either plan is  
5 covered by 29 U.S.C. 1003. This subsection shall be deemed to  
6 be operative on and after July 1, 2025.

7 (b) A contract between a health insurer and a pharmacy  
8 benefit manager must require that the pharmacy benefit  
9 manager:

10 (1) Update maximum allowable cost pricing information  
11 at least every 7 calendar days.

12 (2) Maintain a process that will, in a timely manner,  
13 eliminate drugs from maximum allowable cost lists or  
14 modify drug prices to remain consistent with changes in  
15 pricing data used in formulating maximum allowable cost  
16 prices and product availability.

17 (3) Provide access to its maximum allowable cost list  
18 to each pharmacy or pharmacy services administrative  
19 organization subject to the maximum allowable cost list.  
20 Access may include a real-time pharmacy website portal to  
21 be able to view the maximum allowable cost list. As used in  
22 this Section, "pharmacy services administrative  
23 organization" means an entity operating within the State  
24 that contracts with independent pharmacies to conduct  
25 business on their behalf with third-party payers. A  
26 pharmacy services administrative organization may provide

1 administrative services to pharmacies and negotiate and  
2 enter into contracts with third-party payers or pharmacy  
3 benefit managers on behalf of pharmacies.

4 (4) Provide a process by which a contracted pharmacy  
5 can appeal the provider's reimbursement for a drug subject  
6 to maximum allowable cost pricing. The appeals process  
7 must, at a minimum, include the following:

8 (A) A requirement that a contracted pharmacy has  
9 14 calendar days after the applicable fill date to  
10 appeal a maximum allowable cost if the reimbursement  
11 for the drug is less than the net amount that the  
12 network provider paid to the supplier of the drug.

13 (B) A requirement that a pharmacy benefit manager  
14 must respond to a challenge within 14 calendar days of  
15 the contracted pharmacy making the claim for which the  
16 appeal has been submitted.

17 (C) A telephone number and e-mail address or  
18 website to network providers, at which the provider  
19 can contact the pharmacy benefit manager to process  
20 and submit an appeal.

21 (D) A requirement that, if an appeal is denied,  
22 the pharmacy benefit manager must provide the reason  
23 for the denial and the name and the national drug code  
24 number from national or regional wholesalers.

25 (E) A requirement that, if an appeal is sustained,  
26 the pharmacy benefit manager must make an adjustment

1 in the drug price effective the date the challenge is  
2 resolved and make the adjustment applicable to all  
3 similarly situated network pharmacy providers, as  
4 determined by the managed care organization or  
5 pharmacy benefit manager.

6 (5) Allow a plan sponsor contracting with a pharmacy  
7 benefit manager an annual right to audit compliance with  
8 the terms of the contract by the pharmacy benefit manager,  
9 including, but not limited to, full disclosure of any and  
10 all rebate amounts secured, whether product specific or  
11 generalized rebates, that were provided to the pharmacy  
12 benefit manager by a pharmaceutical manufacturer.

13 (6) Allow a plan sponsor contracting with a pharmacy  
14 benefit manager to request that the pharmacy benefit  
15 manager disclose the actual amounts paid by the pharmacy  
16 benefit manager to the pharmacy.

17 (7) Provide notice to the party contracting with the  
18 pharmacy benefit manager of any consideration that the  
19 pharmacy benefit manager receives from the manufacturer  
20 for dispense as written prescriptions once a generic or  
21 biologically similar product becomes available.

22 (c) In order to place a particular prescription drug on a  
23 maximum allowable cost list, the pharmacy benefit manager  
24 must, at a minimum, ensure that:

25 (1) if the drug is a generically equivalent drug, it  
26 is listed as therapeutically equivalent and

1       pharmaceutically equivalent "A" or "B" rated in the United  
2       States Food and Drug Administration's most recent version  
3       of the "Orange Book" or have an NR or NA rating by  
4       Medi-Span, Gold Standard, or a similar rating by a  
5       nationally recognized reference;

6               (2) the drug is available for purchase by each  
7       pharmacy in the State from national or regional  
8       wholesalers operating in Illinois; and

9               (3) the drug is not obsolete.

10       (d) A pharmacy benefit manager is prohibited from limiting  
11       a pharmacist's ability to disclose whether the cost-sharing  
12       obligation exceeds the retail price for a covered prescription  
13       drug, and the availability of a more affordable alternative  
14       drug, if one is available in accordance with Section 42 of the  
15       Pharmacy Practice Act.

16       (e) A health insurer or pharmacy benefit manager shall not  
17       require an insured to make a payment for a prescription drug at  
18       the point of sale in an amount that exceeds the lesser of:

19               (1) the applicable cost-sharing amount; or

20               (2) the retail price of the drug in the absence of  
21       prescription drug coverage.

22       (f) Unless required by law, a contract between a pharmacy  
23       benefit manager or third-party payer and a 340B entity or 340B  
24       pharmacy shall not contain any provision that:

25               (1) distinguishes between drugs purchased through the  
26       340B drug discount program and other drugs when

1 determining reimbursement or reimbursement methodologies,  
2 or contains otherwise less favorable payment terms or  
3 reimbursement methodologies for 340B entities or 340B  
4 pharmacies when compared to similarly situated non-340B  
5 entities;

6 (2) imposes any fee, chargeback, or rate adjustment  
7 that is not similarly imposed on similarly situated  
8 pharmacies that are not 340B entities or 340B pharmacies;

9 (3) imposes any fee, chargeback, or rate adjustment  
10 that exceeds the fee, chargeback, or rate adjustment that  
11 is not similarly imposed on similarly situated pharmacies  
12 that are not 340B entities or 340B pharmacies;

13 (4) prevents or interferes with an individual's choice  
14 to receive a covered prescription drug from a 340B entity  
15 or 340B pharmacy through any legally permissible means,  
16 except that nothing in this paragraph shall prohibit the  
17 establishment of differing copayments or other  
18 cost-sharing amounts within the benefit plan for covered  
19 persons who acquire covered prescription drugs from a  
20 nonpreferred or nonparticipating provider;

21 (5) excludes a 340B entity or 340B pharmacy from a  
22 pharmacy network on any basis that includes consideration  
23 of whether the 340B entity or 340B pharmacy participates  
24 in the 340B drug discount program;

25 (6) prevents a 340B entity or 340B pharmacy from using  
26 a drug purchased under the 340B drug discount program; or

1           (7) any other provision that discriminates against a  
2           340B entity or 340B pharmacy by treating the 340B entity  
3           or 340B pharmacy differently than non-340B entities or  
4           non-340B pharmacies for any reason relating to the  
5           entity's participation in the 340B drug discount program.

6           As used in this subsection, "pharmacy benefit manager" and  
7           "third-party payer" do not include pharmacy benefit managers  
8           and third-party payers acting on behalf of a Medicaid program.

9           (g) A violation of this Section by a pharmacy benefit  
10          manager constitutes an unfair or deceptive act or practice in  
11          the business of insurance under Section 424.

12          (h) A provision that violates subsection (f) in a contract  
13          between a pharmacy benefit manager or a third-party payer and  
14          a 340B entity that is entered into, amended, or renewed after  
15          July 1, 2022 shall be void and unenforceable.

16          (i)(1) A pharmacy benefit manager may not retaliate  
17          against a pharmacist or pharmacy for disclosing information in  
18          a court, in an administrative hearing, before a legislative  
19          commission or committee, or in any other proceeding, if the  
20          pharmacist or pharmacy has reasonable cause to believe that  
21          the disclosed information is evidence of a violation of a  
22          State or federal law, rule, or regulation.

23          (2) A pharmacy benefit manager may not retaliate against a  
24          pharmacist or pharmacy for disclosing information to a  
25          government or law enforcement agency, if the pharmacist or  
26          pharmacy has reasonable cause to believe that the disclosed

1 information is evidence of a violation of a State or federal  
2 law, rule, or regulation.

3 (3) A pharmacist or pharmacy shall make commercially  
4 reasonable efforts to limit the disclosure of confidential and  
5 proprietary information.

6 (4) Retaliatory actions against a pharmacy or pharmacist  
7 include cancellation of, restriction of, or refusal to renew  
8 or offer a contract to a pharmacy solely because the pharmacy  
9 or pharmacist has:

10 (A) made disclosures of information that the  
11 pharmacist or pharmacy has reasonable cause to believe is  
12 evidence of a violation of a State or federal law, rule, or  
13 regulation;

14 (B) filed complaints with the plan or pharmacy benefit  
15 manager; or

16 (C) filed complaints against the plan or pharmacy  
17 benefit manager with the Department.

18 (j) This Section applies to contracts entered into or  
19 renewed on or after July 1, 2022.

20 (k) This Section applies to any group or individual policy  
21 of accident and health insurance or managed care plan that  
22 provides coverage for prescription drugs and that is amended,  
23 delivered, issued, or renewed on or after July 1, 2020.

24 (m) This Article applies in relation to plan sponsors of  
25 self-funded nonfederal governmental plans only when a State  
26 law organizing the governmental unit incorporates this Article

1 by reference. Nothing shall be construed to exclude a joint  
2 self-insurance pool created under Section 6 of the  
3 Intergovernmental Cooperation Act from references to a plan  
4 sponsor if any pool member's organizing State law incorporates  
5 this Article by reference, but a pharmacy benefit manager is  
6 not subject to the requirements of this Article in relation to  
7 any pool member whose organizing State law does not  
8 incorporate this Article. This subsection shall be deemed to  
9 be operative on and after July 1, 2025.

10 (n) Regardless of whether a health benefit plan is  
11 insurance, the applicability of this Article to a health  
12 benefit plan shall be determined in the same manner as the  
13 determination of whether a person is transacting insurance in  
14 this State under Sections 121-2.03, 121-2.04, and 121-2.05 and  
15 subsections (a), (c), and (e) of Section 121-3. For any health  
16 benefit plan subject to this Article, unless specifically  
17 provided otherwise, this Article applies to all covered  
18 individuals under the health benefit plan, regardless of the  
19 individual's residence. The exemption for group accident and  
20 health insurance described in subsection (c) of Section 352,  
21 as implemented by Department regulation, extends in the same  
22 manner to all other health benefit plans with respect to the  
23 requirements of this Article. This subsection shall be deemed  
24 to be operative on and after July 1, 2025.

25 (Source: P.A. 102-778, eff. 7-1-22; 103-154, eff. 6-30-23;  
26 103-453, eff. 8-4-23.)



1 (Text of Section after amendment by P.A. 104-27)

2 Sec. 513b1. Pharmacy benefit manager contracts.

3 (a) As used in this Article ~~Section~~:

4 "340B drug discount program" means the program established  
5 under Section 340B of the federal Public Health Service Act,  
6 42 U.S.C. 256b.

7 "340B entity" means a covered entity as defined in 42  
8 U.S.C. 256b(a)(4) authorized to participate in the 340B drug  
9 discount program.

10 "340B pharmacy" means any pharmacy used to dispense 340B  
11 drugs for a covered entity, whether entity-owned or external.

12 "Affiliate" means a person or entity that directly or  
13 indirectly through one or more intermediaries controls or is  
14 controlled by, or is under common control with, the person or  
15 entity specified. The location of a person or entity's  
16 domicile, whether in Illinois or a foreign or alien  
17 jurisdiction, does not affect the person or entity's status as  
18 an affiliate.

19 "Biological product" has the meaning ascribed to that term  
20 in Section 19.5 of the Pharmacy Practice Act.

21 "Brand name drug" means a drug that has been approved  
22 under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is  
23 marketed, sold, or distributed under a proprietary,  
24 trademark-protected name.

25 "Complex or chronic medical condition" means a physical,

1 behavioral, or developmental condition that has no known cure,  
2 is progressive, or can be debilitating or fatal if unmanaged  
3 or untreated.

4 "Covered individual" means a member, participant,  
5 enrollee, contract holder, policyholder, or beneficiary of a  
6 health benefit plan who is provided a drug benefit by the  
7 health benefit plan.

8 "Critical access pharmacy" means a critical access care  
9 pharmacy as defined in Section 5-5.12b of the Illinois Public  
10 Aid Code.

11 "Drugs" has the meaning ascribed to that term in Section 3  
12 of the Pharmacy Practice Act and includes biological products.

13 "Employee welfare benefit plan" has the meaning given to  
14 that term in 29 U.S.C. 1002(1), without regard for whether the  
15 employee welfare benefit plan is covered under 29 U.S.C. 1003.

16 "Federal governmental plan" has the meaning given to that  
17 term in 42 U.S.C. 300gg-91(d) (8) (B).

18 "Generic drug" means a drug that has been approved under  
19 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is  
20 marketed, sold, or distributed directly or indirectly to the  
21 retail class of trade with labeling, packaging (other than  
22 repackaging as the listed drug in blister packs, unit doses,  
23 or similar packaging for use in institutions), product code,  
24 labeler code, trade name, or trademark that differs from that  
25 of the brand name drug.

26 "Health benefit plan" means a policy, contract,

1 certificate, or agreement entered into, offered, or issued by  
2 an insurer to provide, deliver, arrange for, pay for, or  
3 reimburse any of the costs of physical, mental, or behavioral  
4 health care services. ~~Notwithstanding Sections 122-1 through~~  
5 ~~122-4 of this Code, "health benefit plan" includes self-funded~~  
6 ~~employee welfare benefit plans.~~ Notwithstanding Sections 122-1  
7 through 122-4 of this Code, "health benefit plan" includes  
8 self-funded employee welfare benefit plans except for  
9 self-funded multiemployer plans that are not nonfederal  
10 government plans. "Health benefit plan" does not include:

11 (1) workers compensation insurance, a federal  
12 governmental plan, Medicare Advantage, Medicare Part D, a  
13 Medicare demonstration program, or Tricare; or

14 (2) any program for dually eligible Medicare-Medicaid  
15 beneficiaries enrolled in a program under which Medicare  
16 pays for most or all of the covered drugs.

17 "Health benefit plan sponsor" or "plan sponsor" means:

18 (1) a plan sponsor, as defined in 29 U.S.C.  
19 1002(16)(B), without regard for whether the employee  
20 welfare benefit plan is covered under 29 U.S.C. 1003.  
21 Except as provided by subsection (m), "plan sponsor"  
22 includes the plan sponsor of a nonfederal governmental  
23 plan, including a joint insurance pool described in  
24 Section 6 of the Intergovernmental Cooperation Act; and

25 (2) any other governmental unit or public agency to  
26 which any State law grants the rights of a plan sponsor

1       when incorporating this Article by reference.

2       "Maximum allowable cost" means the maximum amount that a  
3       pharmacy benefit manager will reimburse a pharmacy for the  
4       cost of a drug.

5       "Maximum allowable cost list" means a list of drugs for  
6       which a maximum allowable cost has been established by a  
7       pharmacy benefit manager.

8       "Multiemployer plan" has the meaning given to that term in  
9       29 U.S.C. 1002(37).

10       "Nonfederal governmental plan" has the meaning given to  
11       that term in 42 U.S.C. 300gg-91(d)(8)(C).

12       "Pharmacy benefit manager" means a person, business, or  
13       entity, including a wholly or partially owned or controlled  
14       subsidiary of a pharmacy benefit manager, that provides claims  
15       processing services or other drug or device services, or both,  
16       for health benefit plans.

17       "Pharmacy" has the meaning given to that term in Section 3  
18       of the Pharmacy Practice Act.

19       "Pharmacy services" means the provision of any services  
20       listed within the definition of "practice of pharmacy" under  
21       subsection (d) of Section 3 of the Pharmacy Practice Act.

22       "Rare medical condition" means a physical, behavioral, or  
23       developmental condition that affects fewer than 200,000  
24       individuals in the United States or approximately 1 in 1,500  
25       individuals worldwide.

26       "Rebate" means a discount or pricing concession based on

1 drug utilization or administration that is paid by the  
2 manufacturer to a pharmacy benefit manager or its client.

3 "Rebate aggregator" means a person or entity, including  
4 group purchasing organizations, that negotiate rebates or  
5 other fees with drug manufacturers on behalf or for the  
6 benefit of a pharmacy benefit manager or its client and may  
7 also be involved in contracts that entitle the rebate  
8 aggregator or its client to receive rebates or other fees from  
9 drug manufacturers based on drug utilization or  
10 administration.

11 "Retail price" means the price an individual without drug  
12 coverage would pay at a retail pharmacy, not including a  
13 pharmacist dispensing fee.

14 "Specialty drug" means a drug that:

15 (1) is prescribed for a person with a complex or  
16 chronic medical condition or a rare medical condition;

17 (2) has limited or exclusive distribution; and

18 (3) requires both:

19 (A) specialized product handling by the dispensing  
20 pharmacy or administration by the dispensing pharmacy;  
21 and

22 (B) specialized clinical care, including frequent  
23 dosing adjustments, intensive clinical monitoring, or  
24 expanded services for patients, including intensive  
25 patient counseling, education, or ongoing clinical  
26 support beyond traditional dispensing activities, such

1 as individualized disease and therapy management to  
2 support improved health outcomes.

3 "Spread pricing" means the model of drug pricing in which  
4 the pharmacy benefit manager charges a health benefit plan a  
5 contracted price for drugs, and the contracted price for the  
6 drugs differs from the amount the pharmacy benefit manager  
7 directly or indirectly pays the pharmacist or pharmacy for the  
8 drugs, pharmacist services, or drug and dispensing fees.

9 "Steer" includes, but is not limited to:

10 (1) requiring a covered individual to only use a  
11 pharmacy, including a mail-order or specialty pharmacy, in  
12 which the pharmacy benefit manager or its affiliate, or an  
13 insurer or its affiliate, maintains an ownership interest  
14 or control;

15 (2) offering or implementing a plan design that  
16 encourages a covered individual to only use a pharmacy in  
17 which the pharmacy benefit manager or an affiliate, or an  
18 insurer or its affiliate, maintains an ownership interest  
19 or control, if the plan design increases costs for the  
20 covered individual. This includes a plan design that  
21 requires a covered individual to pay higher costs or an  
22 increased share of costs for a drug or drug-related  
23 service if the covered individual uses a pharmacy that is  
24 not owned or controlled by the pharmacy benefit manager or  
25 its affiliate or an insurer or its affiliate; and.

26 (3) reimbursing a pharmacy or pharmacist for a drug

1 and pharmacist service in an amount less than the amount  
2 that the pharmacy benefit manager or an insurer reimburses  
3 itself or an affiliate, including affiliated manufacturers  
4 or joint ventures for providing the same drug or service.

5 "Third-party payer" means any entity that pays for drugs  
6 on behalf of a patient other than a health care provider or  
7 sponsor of a plan subject to regulation under Medicare Part D,  
8 42 U.S.C. 1395w-101 et seq.

9 The changes made to this subsection by this amendatory Act  
10 of the 104th General Assembly shall be deemed to be operative  
11 on and after July 1, 2025.

12 (a-5) In this Article, references to an "insurer" or  
13 "health insurer" shall include commercial private health  
14 insurance issuers, managed care organizations, managed care  
15 community networks, and any other third-party payer that  
16 contracts with pharmacy benefit managers or with the  
17 Department of Healthcare and Family Services to provide  
18 benefits or services under the Medicaid program or to  
19 otherwise engage in the administration or payment of pharmacy  
20 benefits. However, the terms do not refer to the plan sponsor  
21 of a self-funded, single-employer employee welfare benefit  
22 plan or self-funded multiemployer plan if either plan is  
23 covered by 29 U.S.C. 1003 ~~subject to 29 U.S.C. 1144.~~ This  
24 subsection shall be deemed to be operative on and after July 1,  
25 2025.

26 (b) A contract between a health insurer or plan sponsor

1 and a pharmacy benefit manager must require that the pharmacy  
2 benefit manager:

3 (1) Update maximum allowable cost pricing information  
4 at least every 7 calendar days.

5 (2) Maintain a process that will, in a timely manner,  
6 eliminate drugs from maximum allowable cost lists or  
7 modify drug prices to remain consistent with changes in  
8 pricing data used in formulating maximum allowable cost  
9 prices and product availability.

10 (3) Provide access to its maximum allowable cost list  
11 to each pharmacy or pharmacy services administrative  
12 organization subject to the maximum allowable cost list.  
13 Access may include a real-time pharmacy website portal to  
14 be able to view the maximum allowable cost list. As used in  
15 this Section, "pharmacy services administrative  
16 organization" means an entity operating within the State  
17 that contracts with independent pharmacies to conduct  
18 business on their behalf with third-party payers. A  
19 pharmacy services administrative organization may provide  
20 administrative services to pharmacies and negotiate and  
21 enter into contracts with third-party payers or pharmacy  
22 benefit managers on behalf of pharmacies.

23 (4) Provide a process by which a contracted pharmacy  
24 can appeal the provider's reimbursement for a drug subject  
25 to maximum allowable cost pricing. The appeals process  
26 must, at a minimum, include the following:



1           (A) A requirement that a contracted pharmacy has  
2           14 calendar days after the applicable fill date to  
3           appeal a maximum allowable cost if the reimbursement  
4           for the drug is less than the net amount that the  
5           network provider paid to the supplier of the drug.

6           (B) A requirement that a pharmacy benefit manager  
7           must respond to a challenge within 14 calendar days of  
8           the contracted pharmacy making the claim for which the  
9           appeal has been submitted.

10          (C) A telephone number and e-mail address or  
11          website to network providers, at which the provider  
12          can contact the pharmacy benefit manager to process  
13          and submit an appeal.

14          (D) A requirement that, if an appeal is denied,  
15          the pharmacy benefit manager must provide the reason  
16          for the denial and the name and the national drug code  
17          number from national or regional wholesalers.

18          (E) A requirement that, if an appeal is sustained,  
19          the pharmacy benefit manager must make an adjustment  
20          in the drug price effective the date the challenge is  
21          resolved and make the adjustment applicable to all  
22          similarly situated network pharmacy providers, as  
23          determined by the managed care organization or  
24          pharmacy benefit manager.

25          (5) Allow a plan sponsor or insurer whose coverage is  
26          administered by the pharmacy benefit manager an annual

1 right to audit compliance with the terms of the contract  
2 by the pharmacy benefit manager, including, but not  
3 limited to, full disclosure of any and all rebate amounts  
4 secured, whether product specific or generalized rebates,  
5 that were provided to the pharmacy benefit manager by a  
6 pharmaceutical manufacturer. The cost of the audit shall  
7 be borne exclusively by the pharmacy benefit manager.

8 (6) Allow a plan sponsor or insurer whose coverage is  
9 administered by the pharmacy benefit manager to request  
10 that the pharmacy benefit manager disclose the actual  
11 amounts paid by the pharmacy benefit manager to the  
12 pharmacy.

13 (7) Provide notice to the plan sponsor or the insurer  
14 party contracting with the pharmacy benefit manager of any  
15 consideration that the pharmacy benefit manager receives  
16 from the manufacturer for dispense as written once a  
17 generic or biologically similar product becomes available.

18 (c) In order to place a particular drug on a maximum  
19 allowable cost list, the pharmacy benefit manager described in  
20 subsection (b) must, at a minimum, ensure that:

21 (1) if the drug is a generically equivalent drug, it  
22 is listed as therapeutically equivalent and  
23 pharmaceutically equivalent "A" or "B" rated in the United  
24 States Food and Drug Administration's most recent version  
25 of the "Orange Book" or have an NR or NA rating by  
26 Medi-Span, Gold Standard, or a similar rating by a

1 nationally recognized reference;

2 (2) the drug is available for purchase by each  
3 pharmacy in the State from national or regional  
4 wholesalers operating in Illinois; and

5 (3) the drug is not obsolete.

6 (d) A pharmacy benefit manager or an insurer is prohibited  
7 from limiting a pharmacist's ability to disclose whether the  
8 cost-sharing obligation exceeds the retail price for a covered  
9 drug, and the availability of a more affordable alternative  
10 drug, if one is available in accordance with Section 42 of the  
11 Pharmacy Practice Act.

12 (e) A health insurer or pharmacy benefit manager shall not  
13 require a covered individual to make a payment for a drug at  
14 the point of sale in an amount that exceeds the lesser of:

15 (1) the applicable cost-sharing amount;

16 (2) the retail price of the drug in the absence of drug  
17 coverage;

18 (3) the discounted price presented by the covered  
19 individual through a no-cost drug program or drug  
20 manufacturer voucher provided by or for the covered  
21 individual at the point of sale; or

22 (4) the discounted price presented by the covered  
23 individual through a discounted health care services plan  
24 provided by or for the covered individual at the point of  
25 sale.

26 This subsection applies to any covered individual of a

1 health benefit plan from an insurer, a nonfederal governmental  
2 plan sponsor, or any other governmental unit or public agency  
3 to which any State law grants the rights of a plan sponsor when  
4 incorporating this Article by reference.

5 (f) Unless required by law, a contract between a pharmacy  
6 benefit manager or third-party payer and a 340B entity or 340B  
7 pharmacy shall not contain any provision that:

8 (1) distinguishes between drugs purchased through the  
9 340B drug discount program and other drugs when  
10 determining reimbursement or reimbursement methodologies,  
11 or contains otherwise less favorable payment terms or  
12 reimbursement methodologies for 340B entities or 340B  
13 pharmacies when compared to similarly situated non-340B  
14 entities;

15 (2) imposes any fee, chargeback, or rate adjustment  
16 that is not similarly imposed on similarly situated  
17 pharmacies that are not 340B entities or 340B pharmacies;

18 (3) imposes any fee, chargeback, or rate adjustment  
19 that exceeds the fee, chargeback, or rate adjustment that  
20 is not similarly imposed on similarly situated pharmacies  
21 that are not 340B entities or 340B pharmacies;

22 (4) prevents or interferes with an individual's choice  
23 to receive a covered drug from a 340B entity or 340B  
24 pharmacy through any legally permissible means, except  
25 that nothing in this paragraph shall prohibit the  
26 establishment of differing copayments or other

1 cost-sharing amounts within the health benefit plan for  
2 covered individuals who acquire covered drugs from a  
3 nonpreferred or nonparticipating provider;

4 (5) excludes a 340B entity or 340B pharmacy from a  
5 pharmacy network on any basis that includes consideration  
6 of whether the 340B entity or 340B pharmacy participates  
7 in the 340B drug discount program;

8 (6) prevents a 340B entity or 340B pharmacy from using  
9 a drug purchased under the 340B drug discount program; or

10 (7) any other provision that discriminates against a  
11 340B entity or 340B pharmacy by treating the 340B entity  
12 or 340B pharmacy differently than non-340B entities or  
13 non-340B pharmacies for any reason relating to the  
14 entity's participation in the 340B drug discount program.

15 As used in this subsection, "pharmacy benefit manager" and  
16 "third-party payer" do not include pharmacy benefit managers  
17 and third-party payers acting on behalf of a Medicaid program.

18 (f-5) A pharmacy benefit manager or an affiliate acting on  
19 its behalf shall not conduct spread pricing.

20 (f-10) A pharmacy benefit manager or an affiliate acting  
21 on its behalf shall not steer a covered individual. This  
22 prohibition also applies to an insurer and its affiliates.

23 Existing agreements entered into before the effective date of  
24 this amendatory Act of the 104th General Assembly shall  
25 supersede this subsection until the termination of the current  
26 term of such agreement.

1 (f-15) A pharmacy benefit manager or affiliated rebate  
2 aggregator must remit no less than 100% of any amounts paid by  
3 a pharmaceutical manufacturer, wholesaler, or other  
4 distributor of a drug, including, but not limited to, rebates,  
5 group purchasing fees, and other fees, to the health benefit  
6 plan sponsor, covered individual, or employer. Records of  
7 rebates and fees remitted from the pharmacy benefit manager or  
8 rebate aggregator must be disclosed to the Department annually  
9 in a format to be specified by the Department. The records  
10 received by the Department shall be considered confidential  
11 and privileged for all purposes, including for purposes of the  
12 Freedom of Information Act, shall not be subject to subpoena  
13 from any private party, and shall not be admissible as  
14 evidence in a civil action.

15 (f-20) A pharmacy benefit manager or an affiliate acting  
16 on its behalf is prohibited from limiting a covered  
17 individual's access to drugs from a pharmacy or pharmacist  
18 enrolled with the health benefit plan under the terms offered  
19 to all pharmacies in the plan coverage area by designating the  
20 covered drug as a specialty drug contrary to the definition in  
21 this Section. This prohibition also applies to an insurer and  
22 its affiliates.

23 (f-25) The contract between the pharmacy benefit manager  
24 and the insurer or health benefit plan sponsor must allow and  
25 provide for the pharmacy benefit manager's compliance with an  
26 audit at least once per calendar year of the rebate and fee

1 records remitted from a pharmacy benefit manager or its  
2 affiliated party to a health benefit plan. This audit may be  
3 incorporated into the audit under paragraph (5) of subsection  
4 (b) of this Section. Contracts with rebate aggregators,  
5 pharmacy services administrative organizations, pharmacies, or  
6 drug manufacturers must be available for audit by health  
7 benefit plan sponsors, insurers, or their designees at least  
8 once per plan year. Audits shall be performed by an auditor  
9 selected by the health benefit plan sponsor, insurer, or its  
10 designee. Health benefit plan sponsors and insurers shall give  
11 the pharmacy benefit manager a complete copy of the audit and  
12 the pharmacy benefit manager shall provide a complete copy of  
13 those findings to the Department within 60 days of initial  
14 receipt. Rebate contracts with rebate aggregators, pharmacy  
15 services administrative organizations, pharmacies, or drug  
16 manufacturers shall be available for audit by health benefit  
17 plan sponsor, insurer, or designee. Nothing in this Section  
18 shall limit the Department's ability to access the books and  
19 records and any and all copies thereof of pharmacy benefit  
20 managers, their affiliates, or affiliated rebate aggregators.  
21 The records received by the Department shall be considered  
22 confidential and privileged for all purposes, including for  
23 purposes of the Freedom of Information Act, shall not be  
24 subject to subpoena from any private party, and shall not be  
25 admissible as evidence in a civil action.

26 (g) A violation of this Section by a pharmacy benefit

1 manager constitutes an unfair or deceptive act or practice in  
2 the business of insurance under Section 424.

3 (h) A provision that violates subsection (f) in a contract  
4 between a pharmacy benefit manager or a third-party payer and  
5 a 340B entity that is entered into, amended, or renewed after  
6 July 1, 2022 shall be void and unenforceable. This subsection  
7 and subsection (f) do not apply to a contract directly between  
8 a 340B entity and the plan sponsor of a self-funded,  
9 single-employer or multiemployer employee welfare benefit plan  
10 subject to 29 U.S.C. 1003 ~~1144~~.

11 (i)(1) A pharmacy benefit manager may not retaliate  
12 against a pharmacist or pharmacy for disclosing information in  
13 a court, in an administrative hearing, before a legislative  
14 commission or committee, or in any other proceeding, if the  
15 pharmacist or pharmacy has reasonable cause to believe that  
16 the disclosed information is evidence of a violation of a  
17 State or federal law, rule, or regulation.

18 (2) A pharmacy benefit manager may not retaliate against a  
19 pharmacist or pharmacy for disclosing information to a  
20 government or law enforcement agency, if the pharmacist or  
21 pharmacy has reasonable cause to believe that the disclosed  
22 information is evidence of a violation of a State or federal  
23 law, rule, or regulation.

24 (3) A pharmacist or pharmacy shall make commercially  
25 reasonable efforts to limit the disclosure of confidential and  
26 proprietary information.



1           (4) Retaliatory actions against a pharmacy or pharmacist  
2 include cancellation of, restriction of, or refusal to renew  
3 or offer a contract to a pharmacy solely because the pharmacy  
4 or pharmacist has:

5           (A) made disclosures of information that the  
6 pharmacist or pharmacy has reasonable cause to believe is  
7 evidence of a violation of a State or federal law, rule, or  
8 regulation;

9           (B) filed complaints with the plan or pharmacy benefit  
10 manager; or

11           (C) filed complaints against the plan or pharmacy  
12 benefit manager with the Department.

13           (j) This Section applies to contracts entered into or  
14 renewed on or after July 1, 2022. Unless and, unless provided  
15 otherwise in this Section or in the Illinois Public Aid Code,  
16 this Section applies to pharmacy benefit managers that are  
17 contracted with a Medicaid managed care entity on or after  
18 January 1, 2026. To the extent not otherwise provided, this  
19 Section applies to contracts entered into, renewed, or amended  
20 on or after January 1, 2026.

21           (k) This Section applies to any health benefit plan that  
22 provides coverage for drugs and that is amended, delivered,  
23 issued, or renewed on or after July 1, 2020. The changes made  
24 to this Section by Public Act 104-27 ~~this amendatory Act of the~~  
25 ~~104th General Assembly~~ shall apply with respect to any health  
26 benefit plan that provides coverage for drugs that is amended,

1 delivered, issued, or renewed on or after January 1, 2026.

2 (l) A pharmacy benefit manager is responsible for  
3 compliance with all State requirements applicable to pharmacy  
4 benefit managers even if an action or responsibility of a  
5 pharmacy benefit manager is delegated to or completed by an  
6 affiliate.

7 (m) This Article applies in relation to plan sponsors of  
8 self-funded nonfederal governmental plans only when a State  
9 law organizing the governmental unit incorporates this Article  
10 by reference. Nothing shall be construed to exclude a joint  
11 self-insurance pool created under Section 6 of the  
12 Intergovernmental Cooperation Act from references to a plan  
13 sponsor if any pool member's organizing State law incorporates  
14 this Article by reference, but a pharmacy benefit manager is  
15 not subject to the requirements of this Article in relation to  
16 any pool member whose organizing State law does not  
17 incorporate this Article. This subsection shall be deemed to  
18 be operative on and after July 1, 2025.

19 (n) Regardless of whether a health benefit plan is  
20 insurance, the applicability of this Article to a health  
21 benefit plan shall be determined in the same manner as the  
22 determination of whether a person is transacting insurance in  
23 this State under Sections 121-2.03, 121-2.04, and 121-2.05 and  
24 subsections (a), (c), and (e) of Section 121-3. For any health  
25 benefit plan subject to this Article, unless specifically  
26 provided otherwise, this Article applies to all covered

1 individuals under the health benefit plan, regardless of the  
2 individual's residence. The exemption for group accident and  
3 health insurance described in subsection (c) of Section 352,  
4 as implemented by Department regulation, extends in the same  
5 manner to all other health benefit plans with respect to the  
6 requirements of this Article. This subsection shall be deemed  
7 to be operative on and after July 1, 2025.

8 (Source: P.A. 103-154, eff. 6-30-23; 103-453, eff. 8-4-23;  
9 104-27, eff. 1-1-26.)

10 (215 ILCS 5/513b1.1)

11 (This Section may contain text from a Public Act with a  
12 delayed effective date)

13 Sec. 513b1.1. Pharmacy benefit manager reporting  
14 requirements.

15 (a) A pharmacy benefit manager that provides services for  
16 a health benefit plan must submit an annual report no later  
17 than September 1, to the Department, each health benefit plan  
18 sponsor, and each insurer that includes the following:

19 (1) data on the health benefit plan including:

20 (A) a list of drugs including corresponding  
21 information on therapeutic class, brand name, generic  
22 name, or specialty drug name;

23 (B) the total number of covered individuals and  
24 number of Illinois residents who are covered  
25 individuals;

1 (C) number of drug-related claims;

2 (D) dosage units;

3 (E) dispensing channel used;

4 (F) average wholesale acquisition cost per drug;

5 and

6 (G) total out-of-pocket spending by deidentified  
7 covered individual per drug, per transaction;

8 (2) amount received by the health benefit plan in  
9 rebates, fees, or discounts related to drug utilization or  
10 spending;

11 (3) total gross spending on drugs by the health  
12 benefit plan;

13 (4) total net spending, gross spending less  
14 administrative portion of the medical loss ratio, on drugs  
15 by the health benefit plan;

16 (5) the amount paid by the health benefit plan to the  
17 pharmacy benefit manager for reimbursement cost of a drug  
18 and service per transaction;

19 (6) the amount a pharmacy benefit manager paid for  
20 pharmacists' services and drugs rendered related to the  
21 health benefit plan per transaction, including, but not  
22 limited to, any dispensing fee;

23 (7) the specific rebate amount received by the  
24 pharmacy benefit manager per transaction, the amount of  
25 the rebates passed through to the health benefit plan per  
26 transaction, and the amount of the rebates passed on to

1 covered individuals at the point of sale that reduced the  
2 covered individuals' applicable deductible, copayment,  
3 coinsurance, or other cost-sharing amount per transaction;

4 (8) any information collected from drug manufacturers  
5 pertaining to copayment assistance to the extent such  
6 information is collected;

7 (9) any compensation paid to brokers, consultants,  
8 advisors, or any other individual or firm for referrals,  
9 consideration, or retention by the health benefit plan;

10 (10) explanation of benefit design parameters  
11 encouraging or requiring covered individuals to use  
12 affiliated pharmacies, percentage of drugs charged by  
13 these pharmacies, and a list of drugs dispensed by  
14 affiliated pharmacies with their associated costs; and

15 (11) a complete copy of each unredacted contract the  
16 pharmacy benefit manager has with the health benefit plan  
17 sponsor or insurer.

18 (b) Annual reports pursuant to subsection (a):

19 (1) must be written in plain language to ensure ease  
20 of reading and accessibility;

21 (2) must only contain summary health information to  
22 ensure plan, coverage, or covered individual information  
23 remains private and confidential;

24 (3) upon request by a covered individual, must be  
25 available in summary format and provide aggregated  
26 information to help covered individuals understand their

1 health benefit plan's drug coverage; and

2 (4) must be filed with the Department no later than  
3 September 1 of each year via the Systems for Electronic  
4 Rates & Forms Filing (SERFF). The filing shall include the  
5 summary version of the report described in paragraph (3)  
6 of this subsection, which shall be marked for public  
7 access.

8 The Department may share all reports with an established  
9 institution of higher education in this State for the creation  
10 of a pharmacist dispensing cost report to be produced  
11 annually. This annual pharmacist dispensing cost report shall  
12 provide a survey of the average cost of dispensing a  
13 prescription for pharmacists in Illinois. The institution of  
14 higher education shall have the ability to request additional  
15 information from pharmacists for its analysis. The institution  
16 of higher education shall issue the report to the General  
17 Assembly no later than December 31, 2026 and annually  
18 thereafter.

19 (c) A pharmacy benefit manager may petition the Department  
20 for a filing submission extension. The Director may grant or  
21 deny the extension within 5 business days.

22 (d) Failure by a pharmacy benefit manager to submit all  
23 required elements in an annual report to the Department may  
24 result in a fine levied by the Director not to exceed \$10,000  
25 per day, per offense. Funds derived from fines levied shall be  
26 deposited into the Insurance Producer Administration Fund.

1 Fine information shall be posted on the Department's website.

2 (e) A pharmacy benefit manager found in violation of  
3 subsection (a) or paragraph (4) of subsection (b) may request  
4 a hearing from the Director within 10 days of receipt of the  
5 Director's order, or, if the violation is found in a market  
6 conduct examination, as provided in Section 132 of this Code.

7 (f) Except for the summary version, the annual reports  
8 submitted by pharmacy benefit managers shall be considered  
9 confidential and privileged for all purposes, including for  
10 purposes of the Freedom of Information Act, shall not be  
11 subject to subpoena from any private party, and shall not be  
12 admissible as evidence in a civil action.

13 (g) A copy of an adverse decision against a pharmacy  
14 benefit manager for failing to submit an annual report to the  
15 Department must be posted to the Department's website.

16 (h) Nothing in this Section shall be construed as  
17 permitting a pharmacy benefit manager to avoid or otherwise  
18 fail to comply with the reporting requirements set forth in  
19 Section 5-36 of the Illinois Public Aid Code.

20 (Source: P.A. 104-27, eff. 1-1-26.)

21 (215 ILCS 5/513b2)

22 Sec. 513b2. Licensure requirements.

23 (a) Beginning on July 1, 2020, to conduct business in this  
24 State, a pharmacy benefit manager must register with the  
25 Director. To initially register or renew a registration, a

1 pharmacy benefit manager shall submit:

2 (1) A nonrefundable fee not to exceed \$500.

3 (2) A copy of the registrant's corporate charter,  
4 articles of incorporation, or other charter document.

5 (3) A completed registration form adopted by the  
6 Director containing:

7 (A) The name and address of the registrant.

8 (B) The name, address, and official position of  
9 each officer and director of the registrant.

10 (b) The registrant shall report any change in information  
11 required under this Section to the Director in writing within  
12 60 days after the change occurs.

13 (c) Upon receipt of a completed registration form, the  
14 required documents, and the registration fee, the Director  
15 shall issue a registration certificate. The certificate may be  
16 in paper or electronic form, and shall clearly indicate the  
17 expiration date of the registration. Registration certificates  
18 are nontransferable.

19 (d) A registration certificate is valid for 2 years after  
20 its date of issue. The Director shall adopt by rule an initial  
21 registration fee not to exceed \$500 and a registration renewal  
22 fee not to exceed \$500, both of which shall be nonrefundable.  
23 Total fees may not exceed the cost of administering this  
24 Section.

25 (e) The Department shall adopt any rules necessary to  
26 implement this Section.



1 (f) On or before August 1, 2025, the pharmacy benefit  
2 manager shall submit a report to the Department that lists the  
3 name of each health benefit plan it administers, provides the  
4 number of Illinois residents who are covered individuals for  
5 each health benefit plan as of the date of submission, and  
6 provides the total number of Illinois residents who are  
7 covered individuals across all health benefit plans the  
8 pharmacy benefit manager administers. On or before September  
9 1, 2025, a registered pharmacy benefit manager, as a condition  
10 of its authority to transact business in this State, must  
11 submit to the Department an amount equal to \$15 or an alternate  
12 amount as determined by the Director by rule per covered  
13 individual enrolled by the pharmacy benefit manager in this  
14 State, as detailed in the report submitted to the Department  
15 under this subsection, during the preceding calendar year. On  
16 or before September 1, 2026 and each September 1 thereafter,  
17 payments submitted under this subsection shall be based on the  
18 number of Illinois residents who are covered individuals  
19 reported to the Department in Section 513b1.1.

20 If a pharmacy benefit manager submitted a payment or  
21 failed to submit a payment under this subsection by September  
22 2, 2025, and if the amount paid or the failure to pay was based  
23 on the pharmacy benefit manager's determination of  
24 applicability or inapplicability to any of its health benefit  
25 plans or covered individuals in a manner contrary to the  
26 requirements clarified by this amendatory Act of the 104th

1 General Assembly, then the pharmacy benefit manager shall  
2 submit a revised report under this subsection by December 1,  
3 2025 in conformity with these clarified requirements. The  
4 revised report shall relate to health benefit plans and  
5 Illinois residents who were covered individuals as of the date  
6 of the previous report. When submitting the revised report,  
7 the pharmacy benefit manager shall identify the types of  
8 health benefit plans and covered individuals that it has added  
9 or removed from its previous report because of the  
10 clarification of applicability. Additionally:

11 (1) If the revised report indicates that the total  
12 number of Illinois residents who were covered individuals  
13 was too low in the previous report, the pharmacy benefit  
14 manager shall pay the difference to the Department by  
15 January 2, 2026.

16 (2) If the revised report indicates that the total  
17 number of Illinois residents who were covered individuals  
18 was too high in the previous report, the pharmacy benefit  
19 manager may request a refund from the Department to the  
20 extent provided in subsection (h). The refund request  
21 shall be included with the submission of the revised  
22 report on or before December 1, 2025.

23 (g) All amounts collected under this Section shall be  
24 deposited into the Prescription Drug Affordability Fund, which  
25 is hereby created as a special fund in the State treasury. Of  
26 the amounts collected under this Section each fiscal year, at

1 the direction of the Department, the Comptroller shall direct  
2 and the Treasurer shall transfer the first \$25,000,000 into  
3 the DCEO Projects Fund for grants to support pharmacies under  
4 Section 605-70 ~~605-60~~ of the Department of Commerce and  
5 Economic Opportunity Law; then, at the direction of the  
6 Department, the Comptroller shall direct and the Treasurer  
7 shall transfer the remainder of the amounts collected under  
8 this Section into the General Revenue Fund.

9 (h) Whenever it appears to the satisfaction of the  
10 Director that because of some mistake of fact, error in  
11 calculation, or erroneous interpretation of a statute of this  
12 State that any pharmacy benefit manager has paid to the  
13 Department an amount under subsection (f) in excess of the  
14 amount required by subsection (f), the Director shall have the  
15 power to refund to the pharmacy benefit manager the amount of  
16 the excess. No refund shall be paid in relation to any health  
17 benefit plan to which State law makes this Article applicable.  
18 No refund shall be paid without the pharmacy benefit manager  
19 first submitting a revised version of the report described in  
20 subsection (f) along with an explanation of the mistake of  
21 fact, error in calculation, or erroneous interpretation of  
22 State statute that caused the overpayment. No refund shall be  
23 paid for any request submitted after December 1, or in a year  
24 when that date falls on a Saturday or Sunday, the first working  
25 day after December 1, of the same calendar year for which a  
26 report was due under subsection (f) that the pharmacy benefit

1 manager claims to have been the basis for an overpayment. If  
2 the Director approves a refund, it shall be paid:

3 (1) by applying the amount thereof toward the payment  
4 of fees or other charges already due to the Department, or  
5 which may thereafter become due to the Department, from  
6 that pharmacy benefit manager until the excess has been  
7 fully refunded; or

8 (2) upon a written request from the pharmacy benefit  
9 manager, the Director shall provide a cash refund within  
10 120 days after receipt of the written request if all  
11 necessary information has been filed with the Department  
12 in order for it to perform an audit of the report described  
13 in subsection (f) or in Section 513b1.1 for the year in  
14 which the overpayment occurred; or within 120 days after  
15 the date the Department receives all the necessary  
16 information to perform the audit.

17 (A) The Director shall not provide a cash refund  
18 if there are insufficient funds in the Prescription  
19 Drug Affordability Fund to provide a cash refund or if  
20 the amount of the overpayment is less than \$100. Funds  
21 shall not be deemed sufficient if the transfer to the  
22 DCEO Projects Fund described in subsection (g) of  
23 Section 513b2 cannot be fully satisfied for the year  
24 of the overpayment.

25 (B) Any cash refund shall be paid from the  
26 Prescription Drug Affordability Fund.

1           (3) In the absence of a rule specific to pharmacy  
2           benefit managers, paragraphs (1) and (2) shall be  
3           implemented in the same manner as provided by Department  
4           rules enacted under Section 412 of this Code to the extent  
5           the rules do not conflict with this subsection.

6           (Source: P.A. 104-2, eff. 7-1-25; 104-27, eff. 7-1-25.)

7           Section 30. The Pharmacy Practice Act is amended by  
8           changing Sections 3 and 9.6 as follows:

9           (225 ILCS 85/3)

10          (Section scheduled to be repealed on January 1, 2028)

11          Sec. 3. Definitions. For the purpose of this Act, except  
12          where otherwise limited therein:

13          (a) "Pharmacy" or "drugstore" means and includes every  
14          store, shop, pharmacy department, or other place where  
15          pharmacist care is provided by a pharmacist (1) where drugs,  
16          medicines, or poisons are dispensed, sold or offered for sale  
17          at retail, or displayed for sale at retail; or (2) where  
18          prescriptions of physicians, dentists, advanced practice  
19          registered nurses, physician assistants, veterinarians,  
20          podiatric physicians, or optometrists, within the limits of  
21          their licenses, are compounded, filled, or dispensed; or (3)  
22          which has upon it or displayed within it, or affixed to or used  
23          in connection with it, a sign bearing the word or words  
24          "Pharmacist", "Druggist", "Pharmacy", "Pharmaceutical Care",

1 "Apothecary", "Drugstore", "Medicine Store", "Prescriptions",  
2 "Drugs", "Dispensary", "Medicines", or any word or words of  
3 similar or like import, either in the English language or any  
4 other language; or (4) where the characteristic prescription  
5 sign (Rx) or similar design is exhibited; or (5) any store, or  
6 shop, or other place with respect to which any of the above  
7 words, objects, signs or designs are used in any  
8 advertisement.

9 (b) "Drugs" means and includes (1) articles recognized in  
10 the official United States Pharmacopoeia/National Formulary  
11 (USP/NF), or any supplement thereto and being intended for and  
12 having for their main use the diagnosis, cure, mitigation,  
13 treatment or prevention of disease in man or other animals, as  
14 approved by the United States Food and Drug Administration,  
15 but does not include devices or their components, parts, or  
16 accessories; and (2) all other articles intended for and  
17 having for their main use the diagnosis, cure, mitigation,  
18 treatment or prevention of disease in man or other animals, as  
19 approved by the United States Food and Drug Administration,  
20 but does not include devices or their components, parts, or  
21 accessories; and (3) articles (other than food) having for  
22 their main use and intended to affect the structure or any  
23 function of the body of man or other animals; and (4) articles  
24 having for their main use and intended for use as a component  
25 or any articles specified in clause (1), (2) or (3); but does  
26 not include devices or their components, parts or accessories.

1 (c) "Medicines" means and includes all drugs intended for  
2 human or veterinary use approved by the United States Food and  
3 Drug Administration.

4 (d) "Practice of pharmacy" means:

5 (1) the interpretation and the provision of assistance  
6 in the monitoring, evaluation, and implementation of  
7 prescription drug orders;

8 (2) the dispensing of prescription drug orders;

9 (3) participation in drug and device selection;

10 (4) drug administration limited to the administration  
11 of oral, topical, injectable, intranasal, and inhalation  
12 as follows:

13 (A) in the context of patient education on the  
14 proper use or delivery of medications;

15 (B) vaccination of patients 3 ~~7~~ years of age and  
16 older pursuant to a valid prescription or standing  
17 order, by a physician licensed to practice medicine in  
18 all its branches, ~~except for vaccinations covered by~~  
19 ~~paragraph (15),~~ upon completion of appropriate  
20 training, including how to address contraindications  
21 and adverse reactions set forth by rule, with  
22 notification to the patient's primary care provider  
23 ~~physician~~ and appropriate record retention, or  
24 pursuant to hospital pharmacy and therapeutics  
25 committee policies and procedures. Eligible vaccines  
26 are those listed on the U.S. Centers for Disease

1 Control and Prevention (CDC) Recommended Immunization  
2 Schedule, the CDC's Health Information for  
3 International Travel, ~~or~~ the U.S. Food and Drug  
4 Administration's Vaccines Licensed and Authorized for  
5 Use in the United States, or the State Guidelines for  
6 Communicable Disease Prevention issued by the Director  
7 of Public Health pursuant to Section 1.2 of the  
8 Communicable Disease Prevention Act, except that a  
9 pharmacist shall not administer to patients below the  
10 age of 7 any vaccine required to be administered under  
11 77 Ill. Adm. Code 665. All vaccines administered in  
12 accordance with this subsection shall be reported to  
13 the Department of Public Health's Immunization  
14 Information System. As applicable to the State's  
15 Medicaid program and other payers, vaccines ordered  
16 and administered in accordance with this subsection  
17 shall be covered and reimbursed at no less than the  
18 rate that the vaccine is reimbursed when ordered and  
19 administered by a physician;

20 (B-5) (blank);

21 (C) administration of injections of  
22 alpha-hydroxyprogesterone caproate, pursuant to a  
23 valid prescription, by a physician licensed to  
24 practice medicine in all its branches, upon completion  
25 of appropriate training, including how to address  
26 contraindications and adverse reactions set forth by



1 rule, with notification to the patient's physician and  
2 appropriate record retention, or pursuant to hospital  
3 pharmacy and therapeutics committee policies and  
4 procedures; and

5 (D) administration of long-acting injectables for  
6 mental health or substance use disorders pursuant to a  
7 valid prescription by the patient's physician licensed  
8 to practice medicine in all its branches, advanced  
9 practice registered nurse, or physician assistant upon  
10 completion of appropriate training conducted by an  
11 Accreditation Council of Pharmaceutical Education  
12 accredited provider, including how to address  
13 contraindications and adverse reactions set forth by  
14 rule, with notification to the patient's physician and  
15 appropriate record retention, or pursuant to hospital  
16 pharmacy and therapeutics committee policies and  
17 procedures;

18 (5) (blank);

19 (6) drug regimen review;

20 (7) drug or drug-related research;

21 (8) the provision of patient counseling;

22 (9) the practice of telepharmacy;

23 (10) the provision of those acts or services necessary  
24 to provide pharmacist care;

25 (11) medication therapy management;

26 (12) the responsibility for compounding and labeling

1 of drugs and devices (except labeling by a manufacturer,  
2 repackager, or distributor of non-prescription drugs and  
3 commercially packaged legend drugs and devices), proper  
4 and safe storage of drugs and devices, and maintenance of  
5 required records;

6 (13) the assessment and consultation of patients and  
7 dispensing of hormonal contraceptives;

8 (14) the initiation, dispensing, or administration of  
9 drugs, laboratory tests, assessments, referrals, and  
10 consultations for human immunodeficiency virus  
11 pre-exposure prophylaxis and human immunodeficiency virus  
12 post-exposure prophylaxis under Section 43.5;

13 (15) without a valid prescription or standing order,  
14 vaccination of patients 3 7 years of age and older for  
15 COVID-19 or influenza ~~subcutaneously,~~ intramuscularly, or  
16 intranasally ~~orally as authorized, approved, or licensed~~  
17 ~~by the United States Food and Drug Administration,~~  
18 pursuant to the following conditions:

19 (A) the vaccine must be authorized or licensed by  
20 the United States Food and Drug Administration;

21 (B) the vaccine must be ordered and administered  
22 according to the recommendations of the Advisory  
23 Committee on Immunization Practices as adopted by the  
24 United States Centers for Disease Control and  
25 Prevention or the State Guidelines for Communicable  
26 Disease Prevention issued by the Director of Public

1       Health pursuant to Section 1.2 of the Communicable  
2       Disease Prevention Act ~~standard immunization schedule;~~

3           (C) the pharmacist must complete a course of  
4       training accredited by the Accreditation Council on  
5       Pharmacy Education or a similar health authority or  
6       professional body approved by the Division of  
7       Professional Regulation;

8           (D) the pharmacist must have a current certificate  
9       in basic cardiopulmonary resuscitation;

10          (E) the pharmacist must complete, during each  
11       State licensing period, a minimum of 2 hours of  
12       immunization-related continuing pharmacy education  
13       approved by the Accreditation Council on Pharmacy  
14       Education;

15          (F) the pharmacist must report all vaccines  
16       administered to the Department of Public Health  
17       Immunization Information System in addition to  
18       complying ~~comply~~ with recordkeeping and reporting  
19       requirements of the jurisdiction in which the  
20       pharmacist administers vaccines, including informing  
21       the patient's primary-care provider, when available,  
22       and complying with requirements whereby the person  
23       administering a vaccine must review the vaccine  
24       registry or other vaccination records prior to  
25       administering the vaccine; and

26          (G) the pharmacist must inform the pharmacist's

1 patients who are less than 18 years old, as well as the  
2 adult caregiver accompanying the child, of the  
3 importance of a well-child visit with a pediatrician  
4 or other licensed primary-care provider and must refer  
5 patients as appropriate;

6 (16) the ordering and administration of COVID-19  
7 therapeutics subcutaneously, intramuscularly, or orally  
8 with notification to the patient's physician and  
9 appropriate record retention or pursuant to hospital  
10 pharmacy and therapeutics committee policies and  
11 procedures. Eligible therapeutics are those approved,  
12 authorized, or licensed by the United States Food and Drug  
13 Administration and must be administered subcutaneously,  
14 intramuscularly, or orally in accordance with that  
15 approval, authorization, or licensing; and

16 (17) the ordering and administration of point of care  
17 tests, screenings, and treatments for (i) influenza, (ii)  
18 SARS-CoV-2, (iii) Group A Streptococcus, (iv) respiratory  
19 syncytial virus, (v) adult-stage head louse, and (vi)  
20 health conditions identified by a statewide public health  
21 emergency, as defined in the Illinois Emergency Management  
22 Agency Act, with notification to the patient's physician,  
23 if any, and appropriate record retention or pursuant to  
24 hospital pharmacy and therapeutics committee policies and  
25 procedures. Eligible tests and screenings are those  
26 approved, authorized, or licensed by the United States

1 Food and Drug Administration and must be administered in  
2 accordance with that approval, authorization, or  
3 licensing.

4 A pharmacist who orders or administers tests or  
5 screenings for health conditions described in this  
6 paragraph may use a test that may guide clinical  
7 decision-making for the health condition that is waived  
8 under the federal Clinical Laboratory Improvement  
9 Amendments of 1988 and regulations promulgated thereunder  
10 or any established screening procedure that is established  
11 under a statewide protocol.

12 A pharmacist may delegate the administrative and  
13 technical tasks of performing a test for the health  
14 conditions described in this paragraph to a registered  
15 pharmacy technician or student pharmacist acting under the  
16 supervision of the pharmacist.

17 The testing, screening, and treatment ordered under  
18 this paragraph by a pharmacist shall not be denied  
19 reimbursement under health benefit plans that are within  
20 the scope of the pharmacist's license and shall be covered  
21 as if the services or procedures were performed by a  
22 physician, an advanced practice registered nurse, or a  
23 physician assistant.

24 A pharmacy benefit manager, health carrier, health  
25 benefit plan, or third-party payor shall not discriminate  
26 against a pharmacy or a pharmacist with respect to

1 participation referral, reimbursement of a covered  
2 service, or indemnification if a pharmacist is acting  
3 within the scope of the pharmacist's license and the  
4 pharmacy is operating in compliance with all applicable  
5 laws and rules.

6 A pharmacist who performs any of the acts defined as the  
7 practice of pharmacy in this State must be actively licensed  
8 as a pharmacist under this Act.

9 (e) "Prescription" means and includes any written, oral,  
10 facsimile, or electronically transmitted order for drugs or  
11 medical devices, issued by a physician licensed to practice  
12 medicine in all its branches, dentist, veterinarian, podiatric  
13 physician, or optometrist, within the limits of his or her  
14 license, by a physician assistant in accordance with  
15 subsection (f) of Section 4, or by an advanced practice  
16 registered nurse in accordance with subsection (g) of Section  
17 4, containing the following: (1) name of the patient; (2) date  
18 when prescription was issued; (3) name and strength of drug or  
19 description of the medical device prescribed; and (4)  
20 quantity; (5) directions for use; (6) prescriber's name,  
21 address, and signature; and (7) DEA registration number where  
22 required, for controlled substances. The prescription may, but  
23 is not required to, list the illness, disease, or condition  
24 for which the drug or device is being prescribed. DEA  
25 registration numbers shall not be required on inpatient drug  
26 orders. A prescription for medication other than controlled

1 substances shall be valid for up to 15 months from the date  
2 issued for the purpose of refills, unless the prescription  
3 states otherwise.

4 (f) "Person" means and includes a natural person,  
5 partnership, association, corporation, government entity, or  
6 any other legal entity.

7 (g) "Department" means the Department of Financial and  
8 Professional Regulation.

9 (h) "Board of Pharmacy" or "Board" means the State Board  
10 of Pharmacy of the Department of Financial and Professional  
11 Regulation.

12 (i) "Secretary" means the Secretary of Financial and  
13 Professional Regulation.

14 (j) "Drug product selection" means the interchange for a  
15 prescribed pharmaceutical product in accordance with Section  
16 25 of this Act and Section 3.14 of the Illinois Food, Drug and  
17 Cosmetic Act.

18 (k) "Inpatient drug order" means an order issued by an  
19 authorized prescriber for a resident or patient of a facility  
20 licensed under the Nursing Home Care Act, the ID/DD Community  
21 Care Act, the MC/DD Act, the Specialized Mental Health  
22 Rehabilitation Act of 2013, the Hospital Licensing Act, or the  
23 University of Illinois Hospital Act, or a facility which is  
24 operated by the Department of Human Services (as successor to  
25 the Department of Mental Health and Developmental  
26 Disabilities) or the Department of Corrections.

1           (k-5) "Pharmacist" means an individual health care  
2 professional and provider currently licensed by this State to  
3 engage in the practice of pharmacy.

4           (1) "Pharmacist in charge" means the licensed pharmacist  
5 whose name appears on a pharmacy license and who is  
6 responsible for all aspects of the operation related to the  
7 practice of pharmacy.

8           (m) "Dispense" or "dispensing" means the interpretation,  
9 evaluation, and implementation of a prescription drug order,  
10 including the preparation and delivery of a drug or device to a  
11 patient or patient's agent in a suitable container  
12 appropriately labeled for subsequent administration to or use  
13 by a patient in accordance with applicable State and federal  
14 laws and regulations. "Dispense" or "dispensing" does not mean  
15 the physical delivery to a patient or a patient's  
16 representative in a home or institution by a designee of a  
17 pharmacist or by common carrier. "Dispense" or "dispensing"  
18 also does not mean the physical delivery of a drug or medical  
19 device to a patient or patient's representative by a  
20 pharmacist's designee within a pharmacy or drugstore while the  
21 pharmacist is on duty and the pharmacy is open.

22           (n) "Nonresident pharmacy" means a pharmacy that is  
23 located in a state, commonwealth, or territory of the United  
24 States, other than Illinois, that delivers, dispenses, or  
25 distributes, through the United States Postal Service,  
26 commercially acceptable parcel delivery service, or other



1 common carrier, to Illinois residents, any substance which  
2 requires a prescription.

3 (o) "Compounding" means the preparation and mixing of  
4 components, excluding flavorings, (1) as the result of a  
5 prescriber's prescription drug order or initiative based on  
6 the prescriber-patient-pharmacist relationship in the course  
7 of professional practice or (2) for the purpose of, or  
8 incident to, research, teaching, or chemical analysis and not  
9 for sale or dispensing. "Compounding" includes the preparation  
10 of drugs or devices in anticipation of receiving prescription  
11 drug orders based on routine, regularly observed dispensing  
12 patterns. Commercially available products may be compounded  
13 for dispensing to individual patients only if all of the  
14 following conditions are met: (i) the commercial product is  
15 not reasonably available from normal distribution channels in  
16 a timely manner to meet the patient's needs and (ii) the  
17 prescribing practitioner has requested that the drug be  
18 compounded.

19 (p) (Blank).

20 (q) (Blank).

21 (r) "Patient counseling" means the communication between a  
22 pharmacist or a student pharmacist under the supervision of a  
23 pharmacist and a patient or the patient's representative about  
24 the patient's medication or device for the purpose of  
25 optimizing proper use of prescription medications or devices.  
26 "Patient counseling" may include without limitation (1)

1 obtaining a medication history; (2) acquiring a patient's  
2 allergies and health conditions; (3) facilitation of the  
3 patient's understanding of the intended use of the medication;  
4 (4) proper directions for use; (5) significant potential  
5 adverse events; (6) potential food-drug interactions; and (7)  
6 the need to be compliant with the medication therapy. A  
7 pharmacy technician may only participate in the following  
8 aspects of patient counseling under the supervision of a  
9 pharmacist: (1) obtaining medication history; (2) providing  
10 the offer for counseling by a pharmacist or student  
11 pharmacist; and (3) acquiring a patient's allergies and health  
12 conditions.

13 (s) "Patient profiles" or "patient drug therapy record"  
14 means the obtaining, recording, and maintenance of patient  
15 prescription information, including prescriptions for  
16 controlled substances, and personal information.

17 (t) (Blank).

18 (u) "Medical device" or "device" means an instrument,  
19 apparatus, implement, machine, contrivance, implant, in vitro  
20 reagent, or other similar or related article, including any  
21 component part or accessory, required under federal law to  
22 bear the label "Caution: Federal law requires dispensing by or  
23 on the order of a physician". A seller of goods and services  
24 who, only for the purpose of retail sales, compounds, sells,  
25 rents, or leases medical devices shall not, by reasons  
26 thereof, be required to be a licensed pharmacy.

1           (v) "Unique identifier" means an electronic signature,  
2           handwritten signature or initials, thumbprint ~~thumb print~~, or  
3           other acceptable biometric or electronic identification  
4           process as approved by the Department.

5           (w) "Current usual and customary retail price" means the  
6           price that a pharmacy charges to a non-third-party payor.

7           (x) "Automated pharmacy system" means a mechanical system  
8           located within the confines of the pharmacy or remote location  
9           that performs operations or activities, other than compounding  
10          or administration, relative to storage, packaging, dispensing,  
11          or distribution of medication, and which collects, controls,  
12          and maintains all transaction information.

13          (y) "Drug regimen review" means and includes the  
14          evaluation of prescription drug orders and patient records for  
15          (1) known allergies; (2) drug or potential therapy  
16          contraindications; (3) reasonable dose, duration of use, and  
17          route of administration, taking into consideration factors  
18          such as age, gender, and contraindications; (4) reasonable  
19          directions for use; (5) potential or actual adverse drug  
20          reactions; (6) drug-drug interactions; (7) drug-food  
21          interactions; (8) drug-disease contraindications; (9)  
22          therapeutic duplication; (10) patient laboratory values when  
23          authorized and available; (11) proper utilization (including  
24          over or under utilization) and optimum therapeutic outcomes;  
25          and (12) abuse and misuse.

26          (z) "Electronically transmitted prescription" means a

1 prescription that is created, recorded, or stored by  
2 electronic means; issued and validated with an electronic  
3 signature; and transmitted by electronic means directly from  
4 the prescriber to a pharmacy. An electronic prescription is  
5 not an image of a physical prescription that is transferred by  
6 electronic means from computer to computer, facsimile to  
7 facsimile, or facsimile to computer.

8 (aa) "Medication therapy management services" means a  
9 distinct service or group of services offered by licensed  
10 pharmacists, physicians licensed to practice medicine in all  
11 its branches, advanced practice registered nurses authorized  
12 in a written agreement with a physician licensed to practice  
13 medicine in all its branches, or physician assistants  
14 authorized in guidelines by a supervising physician that  
15 optimize therapeutic outcomes for individual patients through  
16 improved medication use. In a retail or other non-hospital  
17 pharmacy, medication therapy management services shall consist  
18 of the evaluation of prescription drug orders and patient  
19 medication records to resolve conflicts with the following:

20 (1) known allergies;

21 (2) drug or potential therapy contraindications;

22 (3) reasonable dose, duration of use, and route of  
23 administration, taking into consideration factors such as  
24 age, gender, and contraindications;

25 (4) reasonable directions for use;

26 (5) potential or actual adverse drug reactions;

- 1 (6) drug-drug interactions;
- 2 (7) drug-food interactions;
- 3 (8) drug-disease contraindications;
- 4 (9) identification of therapeutic duplication;
- 5 (10) patient laboratory values when authorized and
- 6 available;
- 7 (11) proper utilization (including over or under
- 8 utilization) and optimum therapeutic outcomes; and
- 9 (12) drug abuse and misuse.

10 "Medication therapy management services" includes the  
11 following:

12 (1) documenting the services delivered and  
13 communicating the information provided to patients'  
14 prescribers within an appropriate time frame, not to  
15 exceed 48 hours;

16 (2) providing patient counseling designed to enhance a  
17 patient's understanding and the appropriate use of his or  
18 her medications; and

19 (3) providing information, support services, and  
20 resources designed to enhance a patient's adherence with  
21 his or her prescribed therapeutic regimens.

22 "Medication therapy management services" may also include  
23 patient care functions authorized by a physician licensed to  
24 practice medicine in all its branches for his or her  
25 identified patient or groups of patients under specified  
26 conditions or limitations in a standing order from the

1 physician.

2 "Medication therapy management services" in a licensed  
3 hospital may also include the following:

4 (1) reviewing assessments of the patient's health  
5 status; and

6 (2) following protocols of a hospital pharmacy and  
7 therapeutics committee with respect to the fulfillment of  
8 medication orders.

9 (bb) "Pharmacist care" means the provision by a pharmacist  
10 of medication therapy management services, with or without the  
11 dispensing of drugs or devices, intended to achieve outcomes  
12 that improve patient health, quality of life, and comfort and  
13 enhance patient safety.

14 (cc) "Protected health information" means individually  
15 identifiable health information that, except as otherwise  
16 provided, is:

17 (1) transmitted by electronic media;

18 (2) maintained in any medium set forth in the  
19 definition of "electronic media" in the federal Health  
20 Insurance Portability and Accountability Act; or

21 (3) transmitted or maintained in any other form or  
22 medium.

23 "Protected health information" does not include  
24 individually identifiable health information found in:

25 (1) education records covered by the federal Family  
26 Educational Right and Privacy Act; or

1           (2) employment records held by a licensee in its role  
2           as an employer.

3           (dd) "Standing order" means a specific order for a patient  
4           or group of patients issued by a physician licensed to  
5           practice medicine in all its branches in Illinois.

6           (ee) "Address of record" means the designated address  
7           recorded by the Department in the applicant's application file  
8           or licensee's license file maintained by the Department's  
9           licensure maintenance unit.

10          (ff) "Home pharmacy" means the location of a pharmacy's  
11          primary operations.

12          (gg) "Email address of record" means the designated email  
13          address recorded by the Department in the applicant's  
14          application file or the licensee's license file, as maintained  
15          by the Department's licensure maintenance unit.

16          (Source: P.A. 102-16, eff. 6-17-21; 102-103, eff. 1-1-22;  
17          102-558, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1051, eff.  
18          1-1-23; 103-1, eff. 4-27-23; 103-593, eff. 6-7-24; 103-612,  
19          eff. 1-1-25; revised 11-26-24.)

20          (225 ILCS 85/9.6)

21          Sec. 9.6. Administration of vaccines and therapeutics by  
22          registered pharmacy technicians and student pharmacists.

23          (a) Under the supervision of an appropriately trained  
24          pharmacist, a registered pharmacy technician or student  
25          pharmacist may administer COVID-19, ~~SARS-CoV-2~~, respiratory

1 syncytial virus, and influenza vaccines ~~subcutaneously,~~  
2 intramuscularly, or intranasally ~~or orally~~ as authorized,  
3 approved, or licensed by the United States Food and Drug  
4 Administration, subject to the following conditions:

5 (1) the vaccination must be ordered by the supervising  
6 pharmacist;

7 (2) the supervising pharmacist must be readily and  
8 immediately available to the immunizing pharmacy  
9 technician or student pharmacist;

10 (3) the pharmacy technician or student pharmacist must  
11 complete a practical training program that is approved by  
12 the Accreditation Council for Pharmacy Education and that  
13 includes hands-on injection technique training and  
14 training in the recognition and treatment of emergency  
15 reactions to vaccines;

16 (4) the pharmacy technician or student pharmacist must  
17 have a current certificate in basic cardiopulmonary  
18 resuscitation;

19 (5) the pharmacy technician or student pharmacist must  
20 complete, during the relevant licensing period, a minimum  
21 of 2 hours of immunization-related continuing pharmacy  
22 education that is approved by the Accreditation Council  
23 for Pharmacy Education;

24 (6) the supervising pharmacist must comply with all  
25 relevant recordkeeping and reporting requirements;

26 (7) the supervising pharmacist must be responsible for



1 complying with requirements related to reporting adverse  
2 events;

3 (8) the supervising pharmacist must review the vaccine  
4 registry or other vaccination records prior to ordering  
5 the vaccination to be administered by the pharmacy  
6 technician or student pharmacist;

7 (9) the pharmacy technician or student pharmacist  
8 must, if the patient is 18 years of age or younger, inform  
9 the patient and the adult caregiver accompanying the  
10 patient of the importance of a well-child visit with a  
11 pediatrician or other licensed primary-care provider and  
12 must refer patients as appropriate;

13 (10) in the case of a COVID-19 vaccine, the  
14 vaccination must be ordered and administered according to  
15 the Advisory Committee on Immunization Practices' COVID-19  
16 vaccine recommendations or the State Guidelines for  
17 Communicable Disease Prevention issued by the Director of  
18 Public Health pursuant to Section 1.2 of the Communicable  
19 Disease Prevention Act;

20 (11) ~~in the case of a COVID-19 vaccine,~~ the  
21 supervising pharmacist must comply with any applicable  
22 requirements or conditions of use as set forth in ~~the~~  
23 ~~Centers for Disease Control and Prevention COVID-19~~  
24 ~~vaccination provider agreement and any other~~ State or  
25 federal requirements that apply to the administration of  
26 the ~~COVID-19~~ vaccines being administered; and

1           (12) the registered pharmacy technician or student  
2 pharmacist and the supervising pharmacist must comply with  
3 all other requirements of this Act and the rules adopted  
4 thereunder pertaining to the administration of drugs.

5           (b) Under the supervision of an appropriately trained  
6 pharmacist, a registered pharmacy technician or student  
7 pharmacist may administer COVID-19 therapeutics  
8 ~~subcutaneously, intramuscularly, or orally as authorized,~~  
9 ~~approved, or licensed by the United States Food and Drug~~  
10 ~~Administration,~~ subject to the following conditions:

11           (1) the COVID-19 therapeutic must be authorized,  
12 approved or licensed by the United States Food and Drug  
13 Administration;

14           (2) the COVID-19 therapeutic must be administered  
15 ~~subcutaneously, intramuscularly, or orally~~ in accordance  
16 with the United States Food and Drug Administration  
17 approval, authorization, or licensing;

18           (3) a pharmacy technician or student pharmacist  
19 practicing pursuant to this Section must complete a  
20 practical training program that is approved by the  
21 Accreditation Council for Pharmacy Education and that  
22 includes hands-on injection technique training, clinical  
23 evaluation of indications and contraindications of  
24 COVID-19 therapeutics training, training in the  
25 recognition and treatment of emergency reactions to  
26 COVID-19 therapeutics, and any additional training

1 required in the United States Food and Drug Administration  
2 approval, authorization, or licensing;

3 (4) the pharmacy technician or student pharmacist must  
4 have a current certificate in basic cardiopulmonary  
5 resuscitation;

6 (5) the pharmacy technician or student pharmacist must  
7 comply with any applicable requirements or conditions of  
8 use that apply to the administration of COVID-19  
9 therapeutics;

10 (6) the supervising pharmacist must comply with all  
11 relevant recordkeeping and reporting requirements;

12 (7) the supervising pharmacist must be readily and  
13 immediately available to the pharmacy technician or  
14 student pharmacist; and

15 (8) the registered pharmacy technician or student  
16 pharmacist and the supervising pharmacist must comply with  
17 all other requirements of this Act and the rules adopted  
18 thereunder pertaining to the administration of drugs.

19 (Source: P.A. 103-1, eff. 4-27-23; 103-593, eff. 6-7-24.)

20 Section 35. The Communicable Disease Prevention Act is  
21 amended by adding Sections 0.05 and 1.2 as follows:

22 (410 ILCS 315/0.05 new)

23 Sec. 0.05. Definitions. For the purposes of this Act:

24 "Immunization" means treatment of an individual with any

1 vaccine or immunologic drug licensed, approved, or authorized  
2 for use by the United States Food and Drug Administration,  
3 including emergency use authorization agents, or meeting World  
4 Health Organization requirements, and designed for the purpose  
5 of producing or enhancing an immune response against a disease  
6 for which such immunization exists.

7 "Medical countermeasures" means products regulated by the  
8 United States Food and Drug Administration that may be used in  
9 a public health emergency stemming from a terrorist attack or  
10 accidental release of a biological, chemical, or  
11 radiological/nuclear agent or a naturally occurring emerging  
12 disease, pandemic, or other large-scale outbreak.

13 (410 ILCS 315/1.2 new)

14 Sec. 1.2. State Guidelines for Communicable Disease  
15 Prevention.

16 (a) The Director of Public Health shall provide State  
17 Guidelines for Communicable Disease Prevention for which there  
18 is an immunization or medical countermeasure. The Guidelines  
19 shall address the use of immunizations and may include  
20 recommendations for the administration of products such as  
21 vaccines or immune globulin preparations that are defined as  
22 immunizations or medical countermeasures and shown to be  
23 effective in controlling a disease for which an immunization  
24 is available. The Guidelines for the use of unlicensed but  
25 regulated immunizations or medical countermeasures may be

1 developed based on medical and scientific evidence if  
2 circumstances warrant. For each immunization or medical  
3 countermeasure, the Guidelines shall include population groups  
4 or circumstances in which a vaccine or related immunization  
5 agent is recommended. The Director of Public Health shall also  
6 provide recommendations on contraindications and precautions  
7 for the use of the immunizations and medical countermeasures  
8 and provide information on recognized adverse events. The  
9 Director also may provide recommendations that address the  
10 general use of immunization products and special situations or  
11 populations that may warrant modification of the routine  
12 recommendations.

13 (b) The Guidelines shall include consideration of disease  
14 epidemiology and the burden of disease, immunization safety,  
15 immunization efficacy and effectiveness, the quality of  
16 evidence reviewed, economic analyses, and implementation  
17 issues. The Director of Public Health may revise or withdraw  
18 recommendations regarding a particular immunization or medical  
19 countermeasure as new information on disease epidemiology,  
20 immunization effectiveness or safety, economic considerations,  
21 or other data become available.

22 (c) In developing these Guidelines, the Director may  
23 consider the advice, recommendations, and feedback of:

24 (1) the Medical Director of the Department of Public  
25 Health;

26 (2) the Immunization Advisory Committee;

1           (3) the Advisory Committee on Immunization Practices  
2           of the United States Centers for Disease Control and  
3           Prevention;

4           (4) medical and scientific experts in the field of  
5           disease prevention; and

6           (5) other widely accepted sources of medical and  
7           scientific evidence, such as recommendations from the  
8           United States Preventive Services Task Force.

9           (d) The Department of Public Health shall publish  
10          Guidelines or recommendations issued by the Director on the  
11          Department's website. The Department of Public Health or the  
12          Director shall not endanger the public health by publishing or  
13          endorsing public health guidelines or recommendations that  
14          significantly deviate from evidence-based immunization  
15          practices established by credible scientific and medical  
16          communities, experts, and practitioners.

17          Section 95. No acceleration or delay. Except for the  
18          changes made in subsections (a), (a-5), (m), and (n) of  
19          Section 513b1 of the Illinois Insurance Code, where this Act  
20          makes changes in a statute that is represented in this Act by  
21          text that is not yet or no longer in effect (for example, a  
22          Section represented by multiple versions), the use of that  
23          text does not accelerate or delay the taking effect of (i) the  
24          changes made by this Act or (ii) provisions derived from any  
25          other Public Act.

1           Section 99. Effective date. This Act takes effect upon  
2   becoming law, except that the changes to Section 424 of the  
3   Illinois Insurance Code take effect January 1, 2026.