



Rep. Bob Morgan

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1 AMENDMENT TO HOUSE BILL 767

2 AMENDMENT NO. _____. Amend House Bill 767 by replacing
3 everything after the enacting clause with the following:

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

1 report directly to the Director. If the Director is not a
2 physician, the Medical Director shall have primary
3 responsibility for overseeing the following regulatory and
4 policy areas:

5 (1) Department responsibilities concerning hospital
6 and health care facility regulation, emergency services,
7 ambulatory surgical treatment centers, health care
8 professional regulation and credentialing, advising the
9 Board of Health, patient safety initiatives, and the
10 State's response to disease prevention and outbreak
11 management and control.

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

22 (3) ~~(2)~~ Any other duties assigned by the Director or
23 required by law.

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

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

6 (2) 5 years of full-time administrative experience in
7 public health and a graduate degree in a related field
8 from (i) a college or university accredited by the North
9 Central Association or (ii) any other nationally
10 recognized regional accrediting agency. For the purposes
11 of this item (2), "a graduate degree in a related field"
12 includes, but is not limited to, a master's degree in
13 public administration, nursing, environmental health,
14 community health, or health education.

15 (c) The Assistant Director of Public Health shall be a
16 person who has administrative experience in public health
17 work.

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

19 Section 10. The Department of Commerce and Economic
20 Opportunity Law of the Civil Administrative Code of Illinois
21 is amended by changing Section 605-60 and adding Section
22 605-70 as follows:

23 (20 ILCS 605/605-60)

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

1 Sec. 605-60. DCEO Projects Fund. The DCEO Projects Fund is
2 created as a trust fund in the State treasury. The Department
3 is authorized to accept and deposit into the Fund moneys
4 received from any gifts, grants, transfers, or other sources,
5 public or private, unless deposit into a different fund is
6 otherwise mandated. Subject to appropriation, the Department
7 shall use moneys in the Fund to make grants or loans to and
8 enter into contracts with units of local government, local and
9 regional economic development corporations, and not-for-profit
10 organizations for municipal development projects, for the
11 specific purposes established by the terms and conditions of
12 the gift, grant, or award, and for related administrative
13 expenses. As used in this Section, the term "municipal
14 development projects" includes, but is not limited to, grants
15 for reducing food insecurity in urban and rural areas.

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

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

18 Sec. 605-60. DCEO Projects Fund.

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

24 (b) Subject to appropriation, the Department shall use
25 moneys in the Fund to make grants or loans to and enter into

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

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

13 ~~Subject to appropriation, the Department shall use moneys~~
14 ~~deposited into the Fund pursuant to Section 513b2 of the~~
15 ~~Illinois Insurance Code to make a grant to a statewide retail~~
16 ~~association representing pharmacies to promote access to~~
17 ~~pharmacies and pharmacist services. Grant funds under this~~
18 ~~subsection shall be made available to the following~~
19 ~~beneficiaries:-~~

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

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

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

1 ~~(4) retail pharmacies with a physical location in a~~
2 ~~county in Illinois with 50,000 or more residents and in an~~
3 ~~area within Illinois that is designated by the United~~
4 ~~States Department of Health and Human Services as either:~~
5 ~~(A) a Medically Underserved Area, including Governor's~~
6 ~~Exceptions; or (B) a Medically Underserved Population,~~
7 ~~including Governor's Exceptions;~~

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

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

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

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

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

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

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

5 ~~(3) the pharmacies that were awarded funding,~~
6 ~~including the location, the amount of funding, and the~~
7 ~~subsection category or categories under which the pharmacy~~
8 ~~qualified.~~

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

10 (20 ILCS 605/605-70 new)

11 Sec. 605-70. Pharmacy support program.

12 (a) Subject to appropriation, the Department shall use
13 moneys deposited into the DCEO Projects Fund pursuant to
14 Section 513b2 of the Illinois Insurance Code to make a grant to
15 a statewide retail association representing pharmacies to
16 promote access to pharmacies and pharmacist services.

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

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

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

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

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

5 (A) a Medically Underserved Area, including
6 Governor's Exceptions; or

7 (B) a Medically Underserved Population, including
8 Governor's Exceptions;

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

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

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

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

26 (c) In subsection (b), "rural tract" and "urban tract"

1 have the meanings given to those terms in Section 5 of the
2 Grocery Initiative Act.

3 (d) Grant funds under subsection (a) shall be disbursed in
4 equal amounts to each beneficiary eligible under subsection
5 (b) that applies for an award. To determine the equal amount
6 available for each beneficiary eligible under subsection (b)
7 each State fiscal year, the total amount appropriated from the
8 DCEO Projects Fund using moneys deposited under Section 513b2
9 of the Illinois Insurance Code less any amount provided to a
10 statewide retail association for administrative expenses shall
11 be divided by the total number of nonduplicate beneficiaries
12 eligible under subsection (b) that apply for an award in the
13 same fiscal year. A beneficiary may only receive one award per
14 fiscal year even if the beneficiary may qualify under multiple
15 beneficiary categories in subsection (b).

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

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

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

23 (3) the pharmacies that were awarded funding,
24 including the location, the amount of funding, and the
25 subsection (b) category or categories under which the
26 pharmacy qualified.

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

3 (20 ILCS 2305/8.4)

4 Sec. 8.4. Immunization Advisory Committee.

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

6 "Committee" means the Immunization Advisory Committee.

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

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

20 (b) The Director of Public Health shall appoint an
21 Immunization Advisory Committee to advise the Director on
22 immunization issues, including:

23 (1) The control of diseases for which an immunization
24 or medical countermeasure is licensed or regulated in the

1 United States by the United States Food and Drug
2 Administration. The advice shall address the use of
3 immunizations or medical countermeasures shown to be
4 effective in controlling a disease for which an
5 immunization is available. Advice for the use of
6 unlicensed but regulated immunizations or medical
7 countermeasures may be provided based on medical and
8 scientific evidence, if circumstances warrant. For each
9 immunization or medical countermeasure, the Committee
10 shall advise on population groups or circumstances in
11 which it is recommended. The Committee shall also provide
12 recommendations on contraindications and precautions for
13 the use of the immunization or medical countermeasures and
14 provide information on recognized adverse events. The
15 Committee may provide recommendations that address the
16 general use of immunizations or medical countermeasures
17 and special situations or populations that may warrant
18 modification of the routine recommendations.

19 (2) The use of immunizations or medical
20 countermeasures to control disease in Illinois, which
21 shall include consideration of disease epidemiology and
22 burden of disease, immunization or medical countermeasure
23 safety, immunization or medical countermeasure efficacy
24 and effectiveness, the quality of evidence reviewed,
25 economic analyses, and implementation issues. The
26 Committee may revise or withdraw its recommendations

1 regarding a particular immunization or medical
2 countermeasure as new information on disease epidemiology,
3 vaccine effectiveness or safety, economic considerations,
4 or other data become available.

5 (3) The Department of Public Health shall publish any
6 recommendations issued by the Immunization Advisory
7 Committee on the Department's website.

8 (c) The Director shall take into consideration any
9 comments or recommendations made by the Immunization Advisory
10 Committee.

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

1 this amendatory Act of the 104th General Assembly may serve 2
2 terms after their current term expires.

3 Members of the Immunization Advisory Committee appointed
4 after the effective date of this amendatory Act of the 104th
5 General Assembly shall include: (i) the Medical Director of
6 the Department of Public Health or the Medical Director's
7 delegate, (ii) a representative from an Illinois local health
8 department, (iii) a certified school nurse or a registered
9 nurse working in a public school, (iv) a public health officer
10 or administrator, (v) a representative of an immunization
11 advocacy organization, (vi) a representative from the State
12 Board of Education, and (vii) licensed health care
13 professionals with knowledge of immunization issues in good
14 standing with the Department of Financial and Professional
15 Regulation, including, but not limited to, a pediatrician, a
16 family physician, an internal medicine physician, an
17 obstetrician-gynecologist, a pharmacist, an academic
18 infectious disease clinician, a public health medical
19 provider, and at least one registered nurse. Physician members
20 must be licensed to practice medicine in all its branches. The
21 Department of Public Health may adopt rules and bylaws, as
22 necessary, on membership eligibility, voting procedures, and
23 other administrative matters for the Immunization Advisory
24 Committee in accordance with the Illinois Administrative
25 Procedure Act and any other applicable laws: a pediatrician, a
26 physician licensed to practice medicine in all its branches, a

1 ~~family physician, an infectious disease specialist from a~~
2 ~~university based center, 2 representatives of a local health~~
3 ~~department, a registered nurse, a school nurse, a public~~
4 ~~health provider, a public health officer or administrator, a~~
5 ~~representative of a children's hospital, 2 representatives of~~
6 ~~immunization advocacy organizations, a representative from the~~
7 ~~State Board of Education, a person with expertise in~~
8 ~~bioterrorism issues, and any other individuals or organization~~
9 ~~representatives designated by the Director.~~ The Director shall
10 designate one of the Advisory Committee members with a degree
11 of doctor of medicine or doctor of osteopathy to serve as the
12 Chairperson of the Advisory Committee.

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

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

2 Section 20. The Illinois Insurance Code is amended by
3 changing Sections 356z.62 and 356z.77 as follows:

4 (215 ILCS 5/356z.62)

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

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

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

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

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

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

6 (5) immunizations and medical countermeasures that
7 have in effect a recommendation within the State
8 Guidelines for Communicable Disease Prevention issued by
9 the Director of Public Health pursuant to Section 1.2 of
10 the Communicable Disease Prevention Act, with respect to
11 the individual involved. For this paragraph, the
12 prohibition on cost-sharing requirements does not apply if
13 and to the extent that the coverage would disqualify a
14 high-deductible health plan from eligibility for a health
15 savings account pursuant to Section 223 of the Internal
16 Revenue Code.

17 (b) For purposes of this Section, and for purposes of any
18 other provision of State law, recommendations of the United
19 States Preventive Services Task Force regarding breast cancer
20 screening, mammography, and prevention issued in or around
21 November 2009 are not considered to be current.

22 (c) For office visits:

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

1 office visit;

2 (2) 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 the delivery of
6 such an item or service, then a policy may not impose
7 cost-sharing requirements with respect to the office
8 visit; and

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

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

26 (1) a recommendation under paragraph (1) of subsection

1 (a) is downgraded to a "D" rating; or

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

6 (d-5) Notwithstanding subsection (d), a policy, including
7 an in-force policy, must provide coverage pursuant to
8 paragraph (5) of subsection (a) within 15 business days after
9 the date the State Guidelines for Communicable Disease
10 Prevention are issued if the Guidelines reinstate any
11 recommendation or portion thereof under paragraph (2) of
12 subsection (a) that the Advisory Committee on Immunization
13 Practices has reduced or withdrawn.

14 (e) Network limitations.

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

24 (2) Subject to paragraph (3) of this subsection,
25 nothing in this Section precludes a policy with a
26 preferred provider program under Article XX-1/2 of this

1 Code, a health maintenance organization point-of-service
2 contract, or a similarly designed voluntary health
3 services plan from imposing cost-sharing requirements for
4 items or services described in subsection (a) that are
5 delivered by an out-of-network provider.

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

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

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

26 (h) The Director may develop guidelines to permit a

1 company to utilize value-based insurance designs. In the
2 absence of guidelines developed by the Director, any such
3 guidelines developed by the Secretary of the U.S. Department
4 of Health and Human Services that are in force under 42 U.S.C.
5 300gg-13 shall apply.

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

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

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

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

5 (215 ILCS 5/356z.77)

6 Sec. 356z.77 ~~356z.71~~. Coverage of vaccination
7 administration fees.

8 (a) A group or individual policy of accident and health
9 insurance or a managed care plan that is amended, delivered,
10 issued, or renewed on or after January 1, 2026 shall provide
11 coverage for vaccinations for COVID-19, influenza, and
12 respiratory syncytial virus, including the administration of
13 the vaccine by a pharmacist or health care provider authorized
14 to administer such a vaccine, without imposing a deductible,
15 coinsurance, copayment, or any other cost-sharing requirement,
16 if the following conditions are met:

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

19 (2) the vaccine is ordered and administered according
20 to the State Guidelines for Communicable Disease
21 Prevention issued by the Director of Public Health
22 pursuant to Section 1.2 of the Communicable Disease
23 Prevention Act or the Advisory Committee on Immunization
24 Practices standard immunization schedule.

25 (b) If the vaccinations provided for in subsection (a) are

1 not otherwise available to be administered by a contracted
2 pharmacist or health care provider, the group or individual
3 policy of accident and health insurance or a managed care plan
4 shall cover the vaccination, including administration fees,
5 without imposing a deductible, coinsurance, copayment, or any
6 other cost-sharing requirement.

7 (c) The coverage required in this Section does not apply
8 to the extent that the coverage would disqualify a
9 high-deductible health plan from eligibility for a health
10 savings account pursuant to Section 223 of the Internal
11 Revenue Code of 1986.

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

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

15 (215 ILCS 5/513b1)

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

17 Sec. 513b1. Pharmacy benefit manager contracts.

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

19 "340B drug discount program" means the program established
20 under Section 340B of the federal Public Health Service Act,
21 42 U.S.C. 256b.

22 "340B entity" means a covered entity as defined in 42
23 U.S.C. 256b(a) (4) authorized to participate in the 340B drug
24 discount program.

1 "340B pharmacy" means any pharmacy used to dispense 340B
2 drugs for a covered entity, whether entity-owned or external.

3 "Affiliate" means a person or entity that directly or
4 indirectly through one or more intermediaries controls or is
5 controlled by, or is under common control with, the person or
6 entity specified. The location of a person or entity's
7 domicile, whether in Illinois or a foreign or alien
8 jurisdiction, does not affect the person or entity's status as
9 an affiliate.

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

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

16 "Complex or chronic medical condition" means a physical,
17 behavioral, or developmental condition that has no known cure,
18 is progressive, or can be debilitating or fatal if unmanaged
19 or untreated.

20 "Covered individual" means a member, participant,
21 enrollee, contract holder, policyholder, or beneficiary of a
22 health benefit plan who is provided a drug benefit by the
23 health benefit plan.

24 "Critical access pharmacy" means a critical access care
25 pharmacy as defined in Section 5-5.12b of the Illinois Public
26 Aid Code.

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

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

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

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

16 "Health benefit plan" means a policy, contract,
17 certificate, or agreement entered into, offered, or issued by
18 an insurer to provide, deliver, arrange for, pay for, or
19 reimburse any of the costs of physical, mental, or behavioral
20 health care services. Notwithstanding Sections 122-1 through
21 122-4 of this Code, "health benefit plan" includes self-funded
22 employee welfare benefit plans except for self-funded
23 multiemployer plans that are not nonfederal government plans.

24 "Health benefit plan" does not include:

25 (1) workers compensation insurance, a federal
26 governmental plan, Medicare Advantage, Medicare Part D, a

1 Medicare demonstration program, or Tricare; or

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

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

6 (1) a plan sponsor, as defined in 29 U.S.C.
7 1002(16)(B), without regard for whether the employee
8 welfare benefit plan is covered under 29 U.S.C. 1003.

9 Except as provided by subsection (m), "plan sponsor"
10 includes the plan sponsor of a nonfederal governmental
11 plan, including a joint insurance pool described in
12 Section 6 of the Intergovernmental Cooperation Act; and

13 (2) any other governmental unit or public agency to
14 which any State law grants the rights of a plan sponsor
15 when incorporating this Article by reference.

16 "Maximum allowable cost" means the maximum amount that a
17 pharmacy benefit manager will reimburse a pharmacy for the
18 cost of a drug.

19 "Maximum allowable cost list" means a list of drugs for
20 which a maximum allowable cost has been established by a
21 pharmacy benefit manager.

22 "Multiemployer plan" has the meaning given to that term in
23 29 U.S.C. 1002(37).

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

26 "Pharmacy benefit manager" means a person, business, or

1 entity, including a wholly or partially owned or controlled
2 subsidiary of a pharmacy benefit manager, that provides claims
3 processing services or other ~~prescription~~ drug or device
4 services, or both, for health benefit plans.

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

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

10 "Rare medical condition" means a physical, behavioral, or
11 developmental condition that affects fewer than 200,000
12 individuals in the United States or approximately 1 in 1,500
13 individuals worldwide.

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

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

25 "Retail price" means the price an individual without
26 ~~prescription~~ drug coverage would pay at a retail pharmacy, not

1 including a pharmacist dispensing fee.

2 "Specialty drug" means a drug that:

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

5 (2) has limited or exclusive distribution; and

6 (3) requires both:

7 (A) specialized product handling by the dispensing
8 pharmacy or administration by the dispensing pharmacy;
9 and

10 (B) specialized clinical care, including frequent
11 dosing adjustments, intensive clinical monitoring, or
12 expanded services for patients, including intensive
13 patient counseling, education, or ongoing clinical
14 support beyond traditional dispensing activities, such
15 as individualized disease and therapy management to
16 support improved health outcomes.

17 "Spread pricing" means the model of drug pricing in which
18 the pharmacy benefit manager charges a health benefit plan a
19 contracted price for drugs, and the contracted price for the
20 drugs differs from the amount the pharmacy benefit manager
21 directly or indirectly pays the pharmacist or pharmacy for the
22 drugs, pharmacist services, or drug and dispensing fees.

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

24 (1) requiring a covered individual to only use a
25 pharmacy, including a mail-order or specialty pharmacy, in
26 which the pharmacy benefit manager or its affiliate, or an

1 insurer or its affiliate, maintains an ownership interest
2 or control;

3 (2) offering or implementing a plan design that
4 encourages a covered individual to only use a pharmacy in
5 which the pharmacy benefit manager or an affiliate, or an
6 insurer or its affiliate, maintains an ownership interest
7 or control, if the plan design increases costs for the
8 covered individual. This includes a plan design that
9 requires a covered individual to pay higher costs or an
10 increased share of costs for a drug or drug-related
11 service if the covered individual uses a pharmacy that is
12 not owned or controlled by the pharmacy benefit manager or
13 its affiliate or an insurer or its affiliate; and

14 (3) reimbursing a pharmacy or pharmacist for a drug
15 and pharmacist service in an amount less than the amount
16 that the pharmacy benefit manager or an insurer reimburses
17 itself or an affiliate, including affiliated manufacturers
18 or joint ventures for providing the same drug or service.

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

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

26 (a-5) In this Article, references to an "insurer" or

1 "health insurer" shall include commercial private health
2 insurance issuers, managed care organizations, managed care
3 community networks, and any other third-party payer that
4 contracts with pharmacy benefit managers or with the
5 Department of Healthcare and Family Services to provide
6 benefits or services under the Medicaid program or to
7 otherwise engage in the administration or payment of pharmacy
8 benefits. However, the terms do not refer to the plan sponsor
9 of a self-funded, single-employer employee welfare benefit
10 plan or self-funded multiemployer plan if either plan is
11 covered by 29 U.S.C. 1003. This subsection shall be deemed to
12 be operative on and after July 1, 2025.

13 (b) A contract between a health insurer and a pharmacy
14 benefit manager must require that the pharmacy benefit
15 manager:

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

18 (2) Maintain a process that will, in a timely manner,
19 eliminate drugs from maximum allowable cost lists or
20 modify drug prices to remain consistent with changes in
21 pricing data used in formulating maximum allowable cost
22 prices and product availability.

23 (3) Provide access to its maximum allowable cost list
24 to each pharmacy or pharmacy services administrative
25 organization subject to the maximum allowable cost list.
26 Access may include a real-time pharmacy website portal to

1 be able to view the maximum allowable cost list. As used in
2 this Section, "pharmacy services administrative
3 organization" means an entity operating within the State
4 that contracts with independent pharmacies to conduct
5 business on their behalf with third-party payers. A
6 pharmacy services administrative organization may provide
7 administrative services to pharmacies and negotiate and
8 enter into contracts with third-party payers or pharmacy
9 benefit managers on behalf of pharmacies.

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

14 (A) A requirement that a contracted pharmacy has
15 14 calendar days after the applicable fill date to
16 appeal a maximum allowable cost if the reimbursement
17 for the drug is less than the net amount that the
18 network provider paid to the supplier of the drug.

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

23 (C) A telephone number and e-mail address or
24 website to network providers, at which the provider
25 can contact the pharmacy benefit manager to process
26 and submit an appeal.

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

5 (E) A requirement that, if an appeal is sustained,
6 the pharmacy benefit manager must make an adjustment
7 in the drug price effective the date the challenge is
8 resolved and make the adjustment applicable to all
9 similarly situated network pharmacy providers, as
10 determined by the managed care organization or
11 pharmacy benefit manager.

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

19 (6) Allow a plan sponsor contracting with a pharmacy
20 benefit manager to request that the pharmacy benefit
21 manager disclose the actual amounts paid by the pharmacy
22 benefit manager to the pharmacy.

23 (7) Provide notice to the party contracting with the
24 pharmacy benefit manager of any consideration that the
25 pharmacy benefit manager receives from the manufacturer
26 for dispense as written prescriptions once a generic or

1 biologically similar product becomes available.

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

5 (1) if the drug is a generically equivalent drug, it
6 is listed as therapeutically equivalent and
7 pharmaceutically equivalent "A" or "B" rated in the United
8 States Food and Drug Administration's most recent version
9 of the "Orange Book" or have an NR or NA rating by
10 Medi-Span, Gold Standard, or a similar rating by a
11 nationally recognized reference;

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

15 (3) the drug is not obsolete.

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

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

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

26 (2) the retail price of the drug in the absence of

1 prescription drug coverage.

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

5 (1) distinguishes between drugs purchased through the
6 340B drug discount program and other drugs when
7 determining reimbursement or reimbursement methodologies,
8 or contains otherwise less favorable payment terms or
9 reimbursement methodologies for 340B entities or 340B
10 pharmacies when compared to similarly situated non-340B
11 entities;

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

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

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

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

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

7 (7) any other provision that discriminates against a
8 340B entity or 340B pharmacy by treating the 340B entity
9 or 340B pharmacy differently than non-340B entities or
10 non-340B pharmacies for any reason relating to the
11 entity's participation in the 340B drug discount program.

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

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

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

22 (i)(1) A pharmacy benefit manager may not retaliate
23 against a pharmacist or pharmacy for disclosing information in
24 a court, in an administrative hearing, before a legislative
25 commission or committee, or in any other proceeding, if the
26 pharmacist or pharmacy has reasonable cause to believe that

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

3 (2) A pharmacy benefit manager may not retaliate against a
4 pharmacist or pharmacy for disclosing information to a
5 government or law enforcement agency, if the pharmacist or
6 pharmacy has reasonable cause to believe that the disclosed
7 information is evidence of a violation of a State or federal
8 law, rule, or regulation.

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

12 (4) Retaliatory actions against a pharmacy or pharmacist
13 include cancellation of, restriction of, or refusal to renew
14 or offer a contract to a pharmacy solely because the pharmacy
15 or pharmacist has:

16 (A) made disclosures of information that the
17 pharmacist or pharmacy has reasonable cause to believe is
18 evidence of a violation of a State or federal law, rule, or
19 regulation;

20 (B) filed complaints with the plan or pharmacy benefit
21 manager; or

22 (C) filed complaints against the plan or pharmacy
23 benefit manager with the Department.

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

26 (k) This Section applies to any group or individual policy

1 of accident and health insurance or managed care plan that
2 provides coverage for prescription drugs and that is amended,
3 delivered, issued, or renewed on or after July 1, 2020.

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

16 (n) Regardless of whether a health benefit plan is
17 insurance, the applicability of this Article to a health
18 benefit plan shall be determined in the same manner as the
19 determination of whether a person is transacting insurance in
20 this State under Sections 121-2.03, 121-2.04, and 121-2.05 and
21 subsections (a), (c), and (e) of Section 121-3. For any health
22 benefit plan subject to this Article, unless specifically
23 provided otherwise, this Article applies to all covered
24 individuals under the health benefit plan, regardless of the
25 individual's residence. The exemption for group accident and
26 health insurance described in subsection (c) of Section 352,

1 as implemented by Department regulation, extends in the same
2 manner to all other health benefit plans with respect to the
3 requirements of this Article. This subsection shall be deemed
4 to be operative on and after July 1, 2025.

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

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

8 Sec. 513b1. Pharmacy benefit manager contracts.

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

10 "340B drug discount program" means the program established
11 under Section 340B of the federal Public Health Service Act,
12 42 U.S.C. 256b.

13 "340B entity" means a covered entity as defined in 42
14 U.S.C. 256b(a)(4) authorized to participate in the 340B drug
15 discount program.

16 "340B pharmacy" means any pharmacy used to dispense 340B
17 drugs for a covered entity, whether entity-owned or external.

18 "Affiliate" means a person or entity that directly or
19 indirectly through one or more intermediaries controls or is
20 controlled by, or is under common control with, the person or
21 entity specified. The location of a person or entity's
22 domicile, whether in Illinois or a foreign or alien
23 jurisdiction, does not affect the person or entity's status as
24 an affiliate.

25 "Biological product" has the meaning ascribed to that term

1 in Section 19.5 of the Pharmacy Practice Act.

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

6 "Complex or chronic medical condition" means a physical,
7 behavioral, or developmental condition that has no known cure,
8 is progressive, or can be debilitating or fatal if unmanaged
9 or untreated.

10 "Covered individual" means a member, participant,
11 enrollee, contract holder, policyholder, or beneficiary of a
12 health benefit plan who is provided a drug benefit by the
13 health benefit plan.

14 "Critical access pharmacy" means a critical access care
15 pharmacy as defined in Section 5-5.12b of the Illinois Public
16 Aid Code.

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

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

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

24 "Generic drug" means a drug that has been approved under
25 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is
26 marketed, sold, or distributed directly or indirectly to the

1 retail class of trade with labeling, packaging (other than
2 repackaging as the listed drug in blister packs, unit doses,
3 or similar packaging for use in institutions), product code,
4 labeler code, trade name, or trademark that differs from that
5 of the brand name drug.

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

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

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

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

24 (1) a plan sponsor, as defined in 29 U.S.C.
25 1002(16)(B), without regard for whether the employee
26 welfare benefit plan is covered under 29 U.S.C. 1003.

1 Except as provided by subsection (m), "plan sponsor"
2 includes the plan sponsor of a nonfederal governmental
3 plan, including a joint insurance pool described in
4 Section 6 of the Intergovernmental Cooperation Act; and

5 (2) any other governmental unit or public agency to
6 which any State law grants the rights of a plan sponsor
7 when incorporating this Article by reference.

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

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

14 "Multiemployer plan" has the meaning given to that term in
15 29 U.S.C. 1002(37).

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

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

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

25 "Pharmacy services" means the provision of any services
26 listed within the definition of "practice of pharmacy" under

1 subsection (d) of Section 3 of the Pharmacy Practice Act.

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

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

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

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

20 "Specialty drug" means a drug that:

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

23 (2) has limited or exclusive distribution; and

24 (3) requires both:

25 (A) specialized product handling by the dispensing
26 pharmacy or administration by the dispensing pharmacy;

1 and

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

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

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

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

21 (2) offering or implementing a plan design that
22 encourages a covered individual to only use a pharmacy in
23 which the pharmacy benefit manager or an affiliate, or an
24 insurer or its affiliate, maintains an ownership interest
25 or control, if the plan design increases costs for the
26 covered individual. This includes a plan design that

1 requires a covered individual to pay higher costs or an
2 increased share of costs for a drug or drug-related
3 service if the covered individual uses a pharmacy that is
4 not owned or controlled by the pharmacy benefit manager or
5 its affiliate or an insurer or its affiliate; and—

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

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

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

18 (a-5) In this Article, references to an "insurer" or
19 "health insurer" shall include commercial private health
20 insurance issuers, managed care organizations, managed care
21 community networks, and any other third-party payer that
22 contracts with pharmacy benefit managers or with the
23 Department of Healthcare and Family Services to provide
24 benefits or services under the Medicaid program or to
25 otherwise engage in the administration or payment of pharmacy
26 benefits. However, the terms do not refer to the plan sponsor

1 of a self-funded, single-employer employee welfare benefit
2 plan or self-funded multiemployer plan if either plan is
3 covered by 29 U.S.C. 1003 ~~subject to 29 U.S.C. 1144.~~ This
4 subsection shall be deemed to be operative on and after July 1,
5 2025.

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

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

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

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

1 enter into contracts with third-party payers or pharmacy
2 benefit managers on behalf of pharmacies.

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

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

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

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

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

24 (E) A requirement that, if an appeal is sustained,
25 the pharmacy benefit manager must make an adjustment
26 in the drug price effective the date the challenge is

1 resolved and make the adjustment applicable to all
2 similarly situated network pharmacy providers, as
3 determined by the managed care organization or
4 pharmacy benefit manager.

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

14 (6) Allow a plan sponsor or insurer whose coverage is
15 administered by the pharmacy benefit manager to request
16 that the pharmacy benefit manager disclose the actual
17 amounts paid by the pharmacy benefit manager to the
18 pharmacy.

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

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

1 (1) if the drug is a generically equivalent drug, it
2 is listed as therapeutically equivalent and
3 pharmaceutically equivalent "A" or "B" rated in the United
4 States Food and Drug Administration's most recent version
5 of the "Orange Book" or have an NR or NA rating by
6 Medi-Span, Gold Standard, or a similar rating by a
7 nationally recognized reference;

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

11 (3) the drug is not obsolete.

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

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

21 (1) the applicable cost-sharing amount;

22 (2) the retail price of the drug in the absence of drug
23 coverage;

24 (3) the discounted price presented by the covered
25 individual through a no-cost drug program or drug
26 manufacturer voucher provided by or for the covered

1 individual at the point of sale; or

2 (4) the discounted price presented by the covered
3 individual through a discounted health care services plan
4 provided by or for the covered individual at the point of
5 sale.

6 This subsection applies to any covered individual of a
7 health benefit plan from an insurer, a nonfederal governmental
8 plan sponsor, or any other governmental unit or public agency
9 to which any State law grants the rights of a plan sponsor when
10 incorporating this Article by reference.

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

14 (1) distinguishes between drugs purchased through the
15 340B drug discount program and other drugs when
16 determining reimbursement or reimbursement methodologies,
17 or contains otherwise less favorable payment terms or
18 reimbursement methodologies for 340B entities or 340B
19 pharmacies when compared to similarly situated non-340B
20 entities;

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

24 (3) imposes any fee, chargeback, or rate adjustment
25 that exceeds the fee, chargeback, or rate adjustment that
26 is not similarly imposed on similarly situated pharmacies

1 that are not 340B entities or 340B pharmacies;

2 (4) prevents or interferes with an individual's choice
3 to receive a covered drug from a 340B entity or 340B
4 pharmacy through any legally permissible means, except
5 that nothing in this paragraph shall prohibit the
6 establishment of differing copayments or other
7 cost-sharing amounts within the health benefit plan for
8 covered individuals who acquire covered drugs from a
9 nonpreferred or nonparticipating provider;

10 (5) excludes a 340B entity or 340B pharmacy from a
11 pharmacy network on any basis that includes consideration
12 of whether the 340B entity or 340B pharmacy participates
13 in the 340B drug discount program;

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

16 (7) any other provision that discriminates against a
17 340B entity or 340B pharmacy by treating the 340B entity
18 or 340B pharmacy differently than non-340B entities or
19 non-340B pharmacies for any reason relating to the
20 entity's participation in the 340B drug discount program.

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

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

26 (f-10) A pharmacy benefit manager or an affiliate acting

1 on its behalf shall not steer a covered individual. This
2 prohibition also applies to an insurer and its affiliates.

3 Existing agreements entered into before the effective date of
4 this amendatory Act of the 104th General Assembly shall
5 supersede this subsection until the termination of the current
6 term of such agreement.

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

21 (f-20) A pharmacy benefit manager or an affiliate acting
22 on its behalf is prohibited from limiting a covered
23 individual's access to drugs from a pharmacy or pharmacist
24 enrolled with the health benefit plan under the terms offered
25 to all pharmacies in the plan coverage area by designating the
26 covered drug as a specialty drug contrary to the definition in

1 this Section. This prohibition also applies to an insurer and
2 its affiliates.

3 (f-25) The contract between the pharmacy benefit manager
4 and the insurer or health benefit plan sponsor must allow and
5 provide for the pharmacy benefit manager's compliance with an
6 audit at least once per calendar year of the rebate and fee
7 records remitted from a pharmacy benefit manager or its
8 affiliated party to a health benefit plan. This audit may be
9 incorporated into the audit under paragraph (5) of subsection
10 (b) of this Section. Contracts with rebate aggregators,
11 pharmacy services administrative organizations, pharmacies, or
12 drug manufacturers must be available for audit by health
13 benefit plan sponsors, insurers, or their designees at least
14 once per plan year. Audits shall be performed by an auditor
15 selected by the health benefit plan sponsor, insurer, or its
16 designee. Health benefit plan sponsors and insurers shall give
17 the pharmacy benefit manager a complete copy of the audit and
18 the pharmacy benefit manager shall provide a complete copy of
19 those findings to the Department within 60 days of initial
20 receipt. Rebate contracts with rebate aggregators, pharmacy
21 services administrative organizations, pharmacies, or drug
22 manufacturers shall be available for audit by health benefit
23 plan sponsor, insurer, or designee. Nothing in this Section
24 shall limit the Department's ability to access the books and
25 records and any and all copies thereof of pharmacy benefit
26 managers, their affiliates, or affiliated rebate aggregators.

1 The records received by the Department shall be considered
2 confidential and privileged for all purposes, including for
3 purposes of the Freedom of Information Act, shall not be
4 subject to subpoena from any private party, and shall not be
5 admissible as evidence in a civil action.

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

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

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

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

1 pharmacy has reasonable cause to believe that the disclosed
2 information is evidence of a violation of a State or federal
3 law, rule, or regulation.

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

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

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

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

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

19 (j) This Section applies to contracts entered into or
20 renewed on or after July 1, 2022. Unless ~~and, unless~~ provided
21 otherwise in this Section or in the Illinois Public Aid Code,
22 this Section applies to pharmacy benefit managers that are
23 contracted with a Medicaid managed care entity on or after
24 January 1, 2026. To the extent not otherwise provided, this
25 Section applies to contracts entered into, renewed, or amended
26 on or after January 1, 2026.

1 (k) This Section applies to any health benefit plan that
2 provides coverage for drugs and that is amended, delivered,
3 issued, or renewed on or after July 1, 2020. The changes made
4 to this Section by Public Act 104-27 ~~this amendatory Act of the~~
5 ~~104th General Assembly~~ shall apply with respect to any health
6 benefit plan that provides coverage for drugs that is amended,
7 delivered, issued, or renewed on or after January 1, 2026.

8 (l) A pharmacy benefit manager is responsible for
9 compliance with all State requirements applicable to pharmacy
10 benefit managers even if an action or responsibility of a
11 pharmacy benefit manager is delegated to or completed by an
12 affiliate.

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

25 (n) Regardless of whether a health benefit plan is
26 insurance, the applicability of this Article to a health

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

14 (Source: P.A. 103-154, eff. 6-30-23; 103-453, eff. 8-4-23;
15 104-27, eff. 1-1-26.)

16 (215 ILCS 5/513b1.1)

17 (This Section may contain text from a Public Act with a
18 delayed effective date)

19 Sec. 513b1.1. Pharmacy benefit manager reporting
20 requirements.

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

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

1 (A) a list of drugs including corresponding
2 information on therapeutic class, brand name, generic
3 name, or specialty drug name;

4 (B) the total number of covered individuals and
5 number of Illinois residents who are covered
6 individuals;

7 (C) number of drug-related claims;

8 (D) dosage units;

9 (E) dispensing channel used;

10 (F) average wholesale acquisition cost per drug;

11 and

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

14 (2) amount received by the health benefit plan in
15 rebates, fees, or discounts related to drug utilization or
16 spending;

17 (3) total gross spending on drugs by the health
18 benefit plan;

19 (4) total net spending, gross spending less
20 administrative portion of the medical loss ratio, on drugs
21 by the health benefit plan;

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

25 (6) the amount a pharmacy benefit manager paid for
26 pharmacists' services and drugs rendered related to the

1 health benefit plan per transaction, including, but not
2 limited to, any dispensing fee;

3 (7) the specific rebate amount received by the
4 pharmacy benefit manager per transaction, the amount of
5 the rebates passed through to the health benefit plan per
6 transaction, and the amount of the rebates passed on to
7 covered individuals at the point of sale that reduced the
8 covered individuals' applicable deductible, copayment,
9 coinsurance, or other cost-sharing amount per transaction;

10 (8) any information collected from drug manufacturers
11 pertaining to copayment assistance to the extent such
12 information is collected;

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

16 (10) explanation of benefit design parameters
17 encouraging or requiring covered individuals to use
18 affiliated pharmacies, percentage of drugs charged by
19 these pharmacies, and a list of drugs dispensed by
20 affiliated pharmacies with their associated costs; and

21 (11) a complete copy of each unredacted contract the
22 pharmacy benefit manager has with the health benefit plan
23 sponsor or insurer.

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

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

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

4 (3) upon request by a covered individual, must be
5 available in summary format and provide aggregated
6 information to help covered individuals understand their
7 health benefit plan's drug coverage; and

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

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

25 (c) A pharmacy benefit manager may petition the Department
26 for a filing submission extension. The Director may grant or

1 deny the extension within 5 business days.

2 (d) Failure by a pharmacy benefit manager to submit all
3 required elements in an annual report to the Department may
4 result in a fine levied by the Director not to exceed \$10,000
5 per day, per offense. Funds derived from fines levied shall be
6 deposited into the Insurance Producer Administration Fund.
7 Fine information shall be posted on the Department's website.

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

13 (f) Except for the summary version, the annual reports
14 submitted by pharmacy benefit managers shall be considered
15 confidential and privileged for all purposes, including for
16 purposes of the Freedom of Information Act, shall not be
17 subject to subpoena from any private party, and shall not be
18 admissible as evidence in a civil action.

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

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

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

1 (215 ILCS 5/513b2)

2 Sec. 513b2. Licensure requirements.

3 (a) Beginning on July 1, 2020, to conduct business in this
4 State, a pharmacy benefit manager must register with the
5 Director. To initially register or renew a registration, a
6 pharmacy benefit manager shall submit:

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

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

10 (3) A completed registration form adopted by the
11 Director containing:

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

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

15 (b) The registrant shall report any change in information
16 required under this Section to the Director in writing within
17 60 days after the change occurs.

18 (c) Upon receipt of a completed registration form, the
19 required documents, and the registration fee, the Director
20 shall issue a registration certificate. The certificate may be
21 in paper or electronic form, and shall clearly indicate the
22 expiration date of the registration. Registration certificates
23 are nontransferable.

24 (d) A registration certificate is valid for 2 years after
25 its date of issue. The Director shall adopt by rule an initial

1 registration fee not to exceed \$500 and a registration renewal
2 fee not to exceed \$500, both of which shall be nonrefundable.
3 Total fees may not exceed the cost of administering this
4 Section.

5 (e) The Department shall adopt any rules necessary to
6 implement this Section.

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

26 If a pharmacy benefit manager submitted a payment or

1 failed to submit a payment under this subsection by September
2 2, 2025, and if the amount paid or the failure to pay was based
3 on the pharmacy benefit manager's determination of
4 applicability or inapplicability to any of its health benefit
5 plans or covered individuals in a manner contrary to the
6 requirements clarified by this amendatory Act of the 104th
7 General Assembly, then the pharmacy benefit manager shall
8 submit a revised report under this subsection by December 1,
9 2025 in conformity with these clarified requirements. The
10 revised report shall relate to health benefit plans and
11 Illinois residents who were covered individuals as of the date
12 of the previous report. When submitting the revised report,
13 the pharmacy benefit manager shall identify the types of
14 health benefit plans and covered individuals that it has added
15 or removed from its previous report because of the
16 clarification of applicability. Additionally:

17 (1) If the revised report indicates that the total
18 number of Illinois residents who were covered individuals
19 was too low in the previous report, the pharmacy benefit
20 manager shall pay the difference to the Department by
21 January 2, 2026.

22 (2) If the revised report indicates that the total
23 number of Illinois residents who were covered individuals
24 was too high in the previous report, the pharmacy benefit
25 manager may request a refund from the Department to the
26 extent provided in subsection (h). The refund request

1 shall be included with the submission of the revised
2 report on or before December 1, 2025.

3 (g) All amounts collected under this Section shall be
4 deposited into the Prescription Drug Affordability Fund, which
5 is hereby created as a special fund in the State treasury. Of
6 the amounts collected under this Section each fiscal year, at
7 the direction of the Department, the Comptroller shall direct
8 and the Treasurer shall transfer the first \$25,000,000 into
9 the DCEO Projects Fund for grants to support pharmacies under
10 Section 605-70 ~~605-60~~ of the Department of Commerce and
11 Economic Opportunity Law; then, at the direction of the
12 Department, the Comptroller shall direct and the Treasurer
13 shall transfer the remainder of the amounts collected under
14 this Section into the General Revenue Fund.

15 (h) Whenever it appears to the satisfaction of the
16 Director that because of some mistake of fact, error in
17 calculation, or erroneous interpretation of a statute of this
18 State that any pharmacy benefit manager has paid to the
19 Department an amount under subsection (f) in excess of the
20 amount required by subsection (f), the Director shall have the
21 power to refund to the pharmacy benefit manager the amount of
22 the excess. No refund shall be paid in relation to any health
23 benefit plan to which State law makes this Article applicable.
24 No refund shall be paid without the pharmacy benefit manager
25 first submitting a revised version of the report described in
26 subsection (f) along with an explanation of the mistake of

1 fact, error in calculation, or erroneous interpretation of
2 State statute that caused the overpayment. No refund shall be
3 paid for any request submitted after December 1, or in a year
4 when that date falls on a Saturday or Sunday, the first working
5 day after December 1, of the same calendar year for which a
6 report was due under subsection (f) that the pharmacy benefit
7 manager claims to have been the basis for an overpayment. If
8 the Director approves a refund, it shall be paid:

9 (1) by applying the amount thereof toward the payment
10 of fees or other charges already due to the Department, or
11 which may thereafter become due to the Department, from
12 that pharmacy benefit manager until the excess has been
13 fully refunded; or

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

23 (A) The Director shall not provide a cash refund
24 if there are insufficient funds in the Prescription
25 Drug Affordability Fund to provide a cash refund or if
26 the amount of the overpayment is less than \$100. Funds

1 shall not be deemed sufficient if the transfer to the
2 DCEO Projects Fund described in subsection (g) of
3 Section 513b2 cannot be fully satisfied for the year
4 of the overpayment.

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

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

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

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

15 (225 ILCS 85/3)

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

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

19 (a) "Pharmacy" or "drugstore" means and includes every
20 store, shop, pharmacy department, or other place where
21 pharmacist care is provided by a pharmacist (1) where drugs,
22 medicines, or poisons are dispensed, sold or offered for sale
23 at retail, or displayed for sale at retail; or (2) where
24 prescriptions of physicians, dentists, advanced practice

1 registered nurses, physician assistants, veterinarians,
2 podiatric physicians, or optometrists, within the limits of
3 their licenses, are compounded, filled, or dispensed; or (3)
4 which has upon it or displayed within it, or affixed to or used
5 in connection with it, a sign bearing the word or words
6 "Pharmacist", "Druggist", "Pharmacy", "Pharmaceutical Care",
7 "Apothecary", "Drugstore", "Medicine Store", "Prescriptions",
8 "Drugs", "Dispensary", "Medicines", or any word or words of
9 similar or like import, either in the English language or any
10 other language; or (4) where the characteristic prescription
11 sign (Rx) or similar design is exhibited; or (5) any store, or
12 shop, or other place with respect to which any of the above
13 words, objects, signs or designs are used in any
14 advertisement.

15 (b) "Drugs" means and includes (1) articles recognized in
16 the official United States Pharmacopoeia/National Formulary
17 (USP/NF), or any supplement thereto and being intended for and
18 having for their main use the diagnosis, cure, mitigation,
19 treatment or prevention of disease in man or other animals, as
20 approved by the United States Food and Drug Administration,
21 but does not include devices or their components, parts, or
22 accessories; and (2) all other articles intended for and
23 having for their main use the diagnosis, cure, mitigation,
24 treatment or prevention of disease in man or other animals, as
25 approved by the United States Food and Drug Administration,
26 but does not include devices or their components, parts, or

1 accessories; and (3) articles (other than food) having for
2 their main use and intended to affect the structure or any
3 function of the body of man or other animals; and (4) articles
4 having for their main use and intended for use as a component
5 or any articles specified in clause (1), (2) or (3); but does
6 not include devices or their components, parts or accessories.

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

10 (d) "Practice of pharmacy" means:

11 (1) the interpretation and the provision of assistance
12 in the monitoring, evaluation, and implementation of
13 prescription drug orders;

14 (2) the dispensing of prescription drug orders;

15 (3) participation in drug and device selection;

16 (4) drug administration limited to the administration
17 of oral, topical, injectable, intranasal, and inhalation
18 as follows:

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

21 (B) vaccination of patients 3 ~~7~~ years of age and
22 older pursuant to a valid prescription or standing
23 order, by a physician licensed to practice medicine in
24 all its branches, except for vaccinations covered by
25 paragraph (15), upon completion of appropriate
26 training, including how to address contraindications

1 and adverse reactions set forth by rule, with
2 notification to the patient's primary care provider
3 ~~physician~~ and appropriate record retention, or
4 pursuant to hospital pharmacy and therapeutics
5 committee policies and procedures. Eligible vaccines
6 are those listed on the U.S. Centers for Disease
7 Control and Prevention (CDC) Recommended Immunization
8 Schedule, the CDC's Health Information for
9 International Travel, ~~or~~ the U.S. Food and Drug
10 Administration's Vaccines Licensed and Authorized for
11 Use in the United States, or the State Guidelines for
12 Communicable Disease Prevention issued by the Director
13 of Public Health pursuant to Section 1.2 of the
14 Communicable Disease Prevention Act, except that a
15 pharmacist shall not administer to patients below the
16 age of 7 any vaccine required to be administered under
17 77 Ill. Adm. Code 665. All vaccines administered in
18 accordance with this subsection shall be reported to
19 the Department of Public Health's Immunization
20 Information System. As applicable to the State's
21 Medicaid program and other payers, vaccines ordered
22 and administered in accordance with this subsection
23 shall be covered and reimbursed at no less than the
24 rate that the vaccine is reimbursed when ordered and
25 administered by a physician;

26 (B-5) (blank);

1 (C) administration of injections of
2 alpha-hydroxyprogesterone caproate, pursuant to a
3 valid prescription, by a physician licensed to
4 practice medicine in all its branches, upon completion
5 of appropriate training, including how to address
6 contraindications and adverse reactions set forth by
7 rule, with notification to the patient's physician and
8 appropriate record retention, or pursuant to hospital
9 pharmacy and therapeutics committee policies and
10 procedures; and

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

24 (5) (blank);

25 (6) drug regimen review;

26 (7) drug or drug-related research;

- 1 (8) the provision of patient counseling;
- 2 (9) the practice of telepharmacy;
- 3 (10) the provision of those acts or services necessary
4 to provide pharmacist care;
- 5 (11) medication therapy management;
- 6 (12) the responsibility for compounding and labeling
7 of drugs and devices (except labeling by a manufacturer,
8 repackager, or distributor of non-prescription drugs and
9 commercially packaged legend drugs and devices), proper
10 and safe storage of drugs and devices, and maintenance of
11 required records;
- 12 (13) the assessment and consultation of patients and
13 dispensing of hormonal contraceptives;
- 14 (14) the initiation, dispensing, or administration of
15 drugs, laboratory tests, assessments, referrals, and
16 consultations for human immunodeficiency virus
17 pre-exposure prophylaxis and human immunodeficiency virus
18 post-exposure prophylaxis under Section 43.5;
- 19 (15) vaccination of patients 3 ~~7~~ years of age and
20 older for COVID-19 or influenza ~~subcutaneously,~~
21 ~~intramuscularly,~~ or intranasally without a valid
22 prescription or standing order, ~~orally as authorized,~~
23 ~~approved, or licensed by the United States Food and Drug~~
24 ~~Administration,~~ pursuant to the following conditions:
- 25 (A) the vaccine must be authorized or licensed by
26 the United States Food and Drug Administration;

1 (B) the vaccine must be ordered and administered
2 according to the recommendations of the Advisory
3 Committee on Immunization Practices as adopted by the
4 United States Centers for Disease Control and
5 Prevention or the State Guidelines for Communicable
6 Disease Prevention issued by the Director of Public
7 Health pursuant to Section 1.2 of the Communicable
8 Disease Prevention Act ~~standard immunization schedule;~~

9 (C) the pharmacist must complete a course of
10 training accredited by the Accreditation Council on
11 Pharmacy Education or a similar health authority or
12 professional body approved by the Division of
13 Professional Regulation;

14 (D) the pharmacist must have a current certificate
15 in basic cardiopulmonary resuscitation;

16 (E) the pharmacist must complete, during each
17 State licensing period, a minimum of 2 hours of
18 immunization-related continuing pharmacy education
19 approved by the Accreditation Council on Pharmacy
20 Education;

21 (F) the pharmacist must report all vaccines
22 administered to the Department of Public Health
23 Immunization Information System in addition to
24 complying ~~comply~~ with recordkeeping and reporting
25 requirements of the jurisdiction in which the
26 pharmacist administers vaccines, including informing

1 the patient's primary-care provider, when available,
2 and complying with requirements whereby the person
3 administering a vaccine must review the vaccine
4 registry or other vaccination records prior to
5 administering the vaccine; and

6 (G) the pharmacist must inform the pharmacist's
7 patients who are less than 18 years old, as well as the
8 adult caregiver accompanying the child, of the
9 importance of a well-child visit with a pediatrician
10 or other licensed primary-care provider and must refer
11 patients as appropriate;

12 (16) the ordering and administration of COVID-19
13 therapeutics subcutaneously, intramuscularly, or orally
14 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. Eligible therapeutics are those approved,
18 authorized, or licensed by the United States Food and Drug
19 Administration and must be administered subcutaneously,
20 intramuscularly, or orally in accordance with that
21 approval, authorization, or licensing; and

22 (17) the ordering and administration of point of care
23 tests, screenings, and treatments for (i) influenza, (ii)
24 SARS-CoV-2, (iii) Group A Streptococcus, (iv) respiratory
25 syncytial virus, (v) adult-stage head louse, and (vi)
26 health conditions identified by a statewide public health

1 emergency, as defined in the Illinois Emergency Management
2 Agency Act, with notification to the patient's physician,
3 if any, and appropriate record retention or pursuant to
4 hospital pharmacy and therapeutics committee policies and
5 procedures. Eligible tests and screenings are those
6 approved, authorized, or licensed by the United States
7 Food and Drug Administration and must be administered in
8 accordance with that approval, authorization, or
9 licensing.

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

18 A pharmacist may delegate the administrative and
19 technical tasks of performing a test for the health
20 conditions described in this paragraph to a registered
21 pharmacy technician or student pharmacist acting under the
22 supervision of the pharmacist.

23 The testing, screening, and treatment ordered under
24 this paragraph by a pharmacist shall not be denied
25 reimbursement under health benefit plans that are within
26 the scope of the pharmacist's license and shall be covered

1 as if the services or procedures were performed by a
2 physician, an advanced practice registered nurse, or a
3 physician assistant.

4 A pharmacy benefit manager, health carrier, health
5 benefit plan, or third-party payor shall not discriminate
6 against a pharmacy or a pharmacist with respect to
7 participation referral, reimbursement of a covered
8 service, or indemnification if a pharmacist is acting
9 within the scope of the pharmacist's license and the
10 pharmacy is operating in compliance with all applicable
11 laws and rules.

12 A pharmacist who performs any of the acts defined as the
13 practice of pharmacy in this State must be actively licensed
14 as a pharmacist under this Act.

15 (e) "Prescription" means and includes any written, oral,
16 facsimile, or electronically transmitted order for drugs or
17 medical devices, issued by a physician licensed to practice
18 medicine in all its branches, dentist, veterinarian, podiatric
19 physician, or optometrist, within the limits of his or her
20 license, by a physician assistant in accordance with
21 subsection (f) of Section 4, or by an advanced practice
22 registered nurse in accordance with subsection (g) of Section
23 4, containing the following: (1) name of the patient; (2) date
24 when prescription was issued; (3) name and strength of drug or
25 description of the medical device prescribed; and (4)
26 quantity; (5) directions for use; (6) prescriber's name,

1 address, and signature; and (7) DEA registration number where
2 required, for controlled substances. The prescription may, but
3 is not required to, list the illness, disease, or condition
4 for which the drug or device is being prescribed. DEA
5 registration numbers shall not be required on inpatient drug
6 orders. A prescription for medication other than controlled
7 substances shall be valid for up to 15 months from the date
8 issued for the purpose of refills, unless the prescription
9 states otherwise.

10 (f) "Person" means and includes a natural person,
11 partnership, association, corporation, government entity, or
12 any other legal entity.

13 (g) "Department" means the Department of Financial and
14 Professional Regulation.

15 (h) "Board of Pharmacy" or "Board" means the State Board
16 of Pharmacy of the Department of Financial and Professional
17 Regulation.

18 (i) "Secretary" means the Secretary of Financial and
19 Professional Regulation.

20 (j) "Drug product selection" means the interchange for a
21 prescribed pharmaceutical product in accordance with Section
22 25 of this Act and Section 3.14 of the Illinois Food, Drug and
23 Cosmetic Act.

24 (k) "Inpatient drug order" means an order issued by an
25 authorized prescriber for a resident or patient of a facility
26 licensed under the Nursing Home Care Act, the ID/DD Community

1 Care Act, the MC/DD Act, the Specialized Mental Health
2 Rehabilitation Act of 2013, the Hospital Licensing Act, or the
3 University of Illinois Hospital Act, or a facility which is
4 operated by the Department of Human Services (as successor to
5 the Department of Mental Health and Developmental
6 Disabilities) or the Department of Corrections.

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

10 (l) "Pharmacist in charge" means the licensed pharmacist
11 whose name appears on a pharmacy license and who is
12 responsible for all aspects of the operation related to the
13 practice of pharmacy.

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

1 pharmacist is on duty and the pharmacy is open.

2 (n) "Nonresident pharmacy" means a pharmacy that is
3 located in a state, commonwealth, or territory of the United
4 States, other than Illinois, that delivers, dispenses, or
5 distributes, through the United States Postal Service,
6 commercially acceptable parcel delivery service, or other
7 common carrier, to Illinois residents, any substance which
8 requires a prescription.

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

25 (p) (Blank).

26 (q) (Blank).

1 (r) "Patient counseling" means the communication between a
2 pharmacist or a student pharmacist under the supervision of a
3 pharmacist and a patient or the patient's representative about
4 the patient's medication or device for the purpose of
5 optimizing proper use of prescription medications or devices.
6 "Patient counseling" may include without limitation (1)
7 obtaining a medication history; (2) acquiring a patient's
8 allergies and health conditions; (3) facilitation of the
9 patient's understanding of the intended use of the medication;
10 (4) proper directions for use; (5) significant potential
11 adverse events; (6) potential food-drug interactions; and (7)
12 the need to be compliant with the medication therapy. A
13 pharmacy technician may only participate in the following
14 aspects of patient counseling under the supervision of a
15 pharmacist: (1) obtaining medication history; (2) providing
16 the offer for counseling by a pharmacist or student
17 pharmacist; and (3) acquiring a patient's allergies and health
18 conditions.

19 (s) "Patient profiles" or "patient drug therapy record"
20 means the obtaining, recording, and maintenance of patient
21 prescription information, including prescriptions for
22 controlled substances, and personal information.

23 (t) (Blank).

24 (u) "Medical device" or "device" means an instrument,
25 apparatus, implement, machine, contrivance, implant, in vitro
26 reagent, or other similar or related article, including any

1 component part or accessory, required under federal law to
2 bear the label "Caution: Federal law requires dispensing by or
3 on the order of a physician". A seller of goods and services
4 who, only for the purpose of retail sales, compounds, sells,
5 rents, or leases medical devices shall not, by reasons
6 thereof, be required to be a licensed pharmacy.

7 (v) "Unique identifier" means an electronic signature,
8 handwritten signature or initials, thumbprint ~~thumb print~~, or
9 other acceptable biometric or electronic identification
10 process as approved by the Department.

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

13 (x) "Automated pharmacy system" means a mechanical system
14 located within the confines of the pharmacy or remote location
15 that performs operations or activities, other than compounding
16 or administration, relative to storage, packaging, dispensing,
17 or distribution of medication, and which collects, controls,
18 and maintains all transaction information.

19 (y) "Drug regimen review" means and includes the
20 evaluation of prescription drug orders and patient records for
21 (1) known allergies; (2) drug or potential therapy
22 contraindications; (3) reasonable dose, duration of use, and
23 route of administration, taking into consideration factors
24 such as age, gender, and contraindications; (4) reasonable
25 directions for use; (5) potential or actual adverse drug
26 reactions; (6) drug-drug interactions; (7) drug-food

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

6 (z) "Electronically transmitted prescription" means a
7 prescription that is created, recorded, or stored by
8 electronic means; issued and validated with an electronic
9 signature; and transmitted by electronic means directly from
10 the prescriber to a pharmacy. An electronic prescription is
11 not an image of a physical prescription that is transferred by
12 electronic means from computer to computer, facsimile to
13 facsimile, or facsimile to computer.

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

26 (1) known allergies;

- 1 (2) drug or potential therapy contraindications;
- 2 (3) reasonable dose, duration of use, and route of
- 3 administration, taking into consideration factors such as
- 4 age, gender, and contraindications;
- 5 (4) reasonable directions for use;
- 6 (5) potential or actual adverse drug reactions;
- 7 (6) drug-drug interactions;
- 8 (7) drug-food interactions;
- 9 (8) drug-disease contraindications;
- 10 (9) identification of therapeutic duplication;
- 11 (10) patient laboratory values when authorized and
- 12 available;
- 13 (11) proper utilization (including over or under
- 14 utilization) and optimum therapeutic outcomes; and
- 15 (12) drug abuse and misuse.

16 "Medication therapy management services" includes the
17 following:

- 18 (1) documenting the services delivered and
- 19 communicating the information provided to patients'
- 20 prescribers within an appropriate time frame, not to
- 21 exceed 48 hours;
- 22 (2) providing patient counseling designed to enhance a
- 23 patient's understanding and the appropriate use of his or
- 24 her medications; and
- 25 (3) providing information, support services, and
- 26 resources designed to enhance a patient's adherence with

1 his or her prescribed therapeutic regimens.

2 "Medication therapy management services" may also include
3 patient care functions authorized by a physician licensed to
4 practice medicine in all its branches for his or her
5 identified patient or groups of patients under specified
6 conditions or limitations in a standing order from the
7 physician.

8 "Medication therapy management services" in a licensed
9 hospital may also include the following:

10 (1) reviewing assessments of the patient's health
11 status; and

12 (2) following protocols of a hospital pharmacy and
13 therapeutics committee with respect to the fulfillment of
14 medication orders.

15 (bb) "Pharmacist care" means the provision by a pharmacist
16 of medication therapy management services, with or without the
17 dispensing of drugs or devices, intended to achieve outcomes
18 that improve patient health, quality of life, and comfort and
19 enhance patient safety.

20 (cc) "Protected health information" means individually
21 identifiable health information that, except as otherwise
22 provided, is:

23 (1) transmitted by electronic media;

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

1 (3) transmitted or maintained in any other form or
2 medium.

3 "Protected health information" does not include
4 individually identifiable health information found in:

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

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

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

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

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

18 (gg) "Email address of record" means the designated email
19 address recorded by the Department in the applicant's
20 application file or the licensee's license file, as maintained
21 by the Department's licensure maintenance unit.

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

1 (225 ILCS 85/9.6)

2 Sec. 9.6. Administration of vaccines and therapeutics by
3 registered pharmacy technicians and student pharmacists.

4 (a) Under the supervision of an appropriately trained
5 pharmacist, a registered pharmacy technician or student
6 pharmacist may administer COVID-19, ~~SARS-CoV-2~~, respiratory
7 syncytial virus, and influenza vaccines ~~subcutaneously,~~
8 ~~intramuscularly,~~ or intranasally ~~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 vaccination must be ordered by the supervising
12 pharmacist;

13 (2) the supervising pharmacist must be readily and
14 immediately available to the immunizing pharmacy
15 technician or student pharmacist;

16 (3) the pharmacy technician or student pharmacist must
17 complete a practical training program that is approved by
18 the Accreditation Council for Pharmacy Education and that
19 includes hands-on injection technique training and
20 training in the recognition and treatment of emergency
21 reactions to vaccines;

22 (4) the pharmacy technician or student pharmacist must
23 have a current certificate in basic cardiopulmonary
24 resuscitation;

25 (5) the pharmacy technician or student pharmacist must
26 complete, during the relevant licensing period, a minimum

1 of 2 hours of immunization-related continuing pharmacy
2 education that is approved by the Accreditation Council
3 for Pharmacy Education;

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

6 (7) the supervising pharmacist must be responsible for
7 complying with requirements related to reporting adverse
8 events;

9 (8) the supervising pharmacist must review the vaccine
10 registry or other vaccination records prior to ordering
11 the vaccination to be administered by the pharmacy
12 technician or student pharmacist;

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

19 (10) in the case of a COVID-19 vaccine, the
20 vaccination must be ordered and administered according to
21 the Advisory Committee on Immunization Practices' COVID-19
22 vaccine recommendations or the State Guidelines for
23 Communicable Disease Prevention issued by the Director of
24 Public Health pursuant to Section 1.2 of the Communicable
25 Disease Prevention Act;

26 (11) ~~in the case of a COVID 19 vaccine,~~ the

1 supervising pharmacist must comply with any applicable
2 requirements or conditions of use as set forth in ~~the~~
3 ~~Centers for Disease Control and Prevention COVID-19~~
4 ~~vaccination provider agreement and any other~~ State or
5 federal requirements that apply to the administration of
6 the COVID-19 vaccines being administered; and

7 (12) the registered pharmacy technician or student
8 pharmacist and the supervising pharmacist must comply with
9 all other requirements of this Act and the rules adopted
10 thereunder pertaining to the administration of drugs.

11 (b) Under the supervision of an appropriately trained
12 pharmacist, a registered pharmacy technician or student
13 pharmacist may administer COVID-19 therapeutics
14 ~~subcutaneously, intramuscularly, or orally as authorized,~~
15 ~~approved, or licensed by the United States Food and Drug~~
16 ~~Administration,~~ subject to the following conditions:

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

20 (2) the COVID-19 therapeutic must be administered
21 ~~subcutaneously, intramuscularly, or orally~~ in accordance
22 with the United States Food and Drug Administration
23 approval, authorization, or licensing;

24 (3) a pharmacy technician or student pharmacist
25 practicing pursuant to this Section must complete a
26 practical training program that is approved by the

1 Accreditation Council for Pharmacy Education and that
2 includes hands-on injection technique training, clinical
3 evaluation of indications and contraindications of
4 COVID-19 therapeutics training, training in the
5 recognition and treatment of emergency reactions to
6 COVID-19 therapeutics, and any additional training
7 required in the United States Food and Drug Administration
8 approval, authorization, or licensing;

9 (4) the pharmacy technician or student pharmacist must
10 have a current certificate in basic cardiopulmonary
11 resuscitation;

12 (5) the pharmacy technician or student pharmacist must
13 comply with any applicable requirements or conditions of
14 use that apply to the administration of COVID-19
15 therapeutics;

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

18 (7) the supervising pharmacist must be readily and
19 immediately available to the pharmacy technician or
20 student pharmacist; and

21 (8) the registered pharmacy technician or student
22 pharmacist and the supervising pharmacist must comply with
23 all other requirements of this Act and the rules adopted
24 thereunder pertaining to the administration of drugs.

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

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

3 (410 ILCS 315/0.05 new)

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

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

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

18 (410 ILCS 315/1.2 new)

19 Sec. 1.2. State Guidelines for Communicable Disease
20 Prevention.

21 (a) The Director of Public Health shall provide State
22 Guidelines for Communicable Disease Prevention for which there
23 is an immunization or medical countermeasure. The Guidelines
24 shall address the use of immunizations and may include

1 recommendations for the administration of products such as
2 vaccines or immune globulin preparations that are defined as
3 immunizations or medical countermeasures and shown to be
4 effective in controlling a disease for which an immunization
5 is available. The Guidelines for the use of unlicensed but
6 regulated immunizations or medical countermeasures may be
7 developed based on medical and scientific evidence if
8 circumstances warrant. For each immunization or medical
9 countermeasure, the Guidelines shall include population groups
10 or circumstances in which a vaccine or related immunization
11 agent is recommended. The Director of Public Health shall also
12 provide recommendations on contraindications and precautions
13 for the use of the immunizations and medical countermeasures
14 and provide information on recognized adverse events. The
15 Director also may provide recommendations that address the
16 general use of immunization products and special situations or
17 populations that may warrant modification of the routine
18 recommendations.

19 (b) The Guidelines shall include consideration of disease
20 epidemiology and the burden of disease, immunization safety,
21 immunization efficacy and effectiveness, the quality of
22 evidence reviewed, economic analyses, and implementation
23 issues. The Director of Public Health may revise or withdraw
24 recommendations regarding a particular immunization or medical
25 countermeasure as new information on disease epidemiology,
26 immunization effectiveness or safety, economic considerations,

1 or other data become available.

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

4 (1) the Medical Director of the Department of Public
5 Health;

6 (2) the Immunization Advisory Committee;

7 (3) the Advisory Committee on Immunization Practices
8 of the United States Centers for Disease Control and
9 Prevention;

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

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

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

23 Section 95. No acceleration or delay. Except for the
24 changes made in subsections (a), (a-5), (m), and (n) of
25 Section 513b1 of the Illinois Insurance Code, where this Act

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

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