

1 AN ACT concerning regulation.

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

4 Section 5. The Network Adequacy and Transparency Act is
5 amended by changing Section 10 as follows:

6 (215 ILCS 124/10)

7 (Text of Section from P.A. 103-650)

8 Sec. 10. Network adequacy.

9 (a) Before issuing, delivering, or renewing a network
10 plan, an issuer providing a network plan shall file a
11 description of all of the following with the Director:

12 (1) The written policies and procedures for adding
13 providers to meet patient needs based on increases in the
14 number of beneficiaries, changes in the
15 patient-to-provider ratio, changes in medical and health
16 care capabilities, and increased demand for services.

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

19 (3) The written policies and procedures on how the
20 network plan will provide 24-hour, 7-day per week access
21 to network-affiliated primary care, emergency services,
22 and women's principal health care providers.

23 An issuer shall not prohibit a preferred provider from

1 discussing any specific or all treatment options with
2 beneficiaries irrespective of the insurer's position on those
3 treatment options or from advocating on behalf of
4 beneficiaries within the utilization review, grievance, or
5 appeals processes established by the issuer in accordance with
6 any rights or remedies available under applicable State or
7 federal law.

8 (b) Before issuing, delivering, or renewing a network
9 plan, an issuer must file for review a description of the
10 services to be offered through a network plan. The description
11 shall include all of the following:

12 (1) A geographic map of the area proposed to be served
13 by the plan by county service area and zip code, including
14 marked locations for preferred providers.

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

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

21 (4) An Internet website and toll-free telephone number
22 for beneficiaries and prospective beneficiaries to access
23 current and accurate lists of preferred providers in each
24 plan, additional information about the plan, as well as
25 any other information required by Department rule.

26 (5) A description of how health care services to be

1 rendered under the network plan are reasonably accessible
2 and available to beneficiaries. The description shall
3 address all of the following:

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

6 (B) the ratio of physicians and other providers to
7 beneficiaries, by specialty and including primary care
8 physicians and facility-based physicians when
9 applicable under the contract, necessary to meet the
10 health care needs and service demands of the currently
11 enrolled population;

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

14 (D) a description of how the use of telemedicine,
15 telehealth, or mobile care services may be used to
16 partially meet the network adequacy standards, if
17 applicable.

18 (6) A provision ensuring that whenever a beneficiary
19 has made a good faith effort, as evidenced by accessing
20 the provider directory, calling the network plan, and
21 calling the provider, to utilize preferred providers for a
22 covered service and it is determined the insurer does not
23 have the appropriate preferred providers due to
24 insufficient number, type, unreasonable travel distance or
25 delay, or preferred providers refusing to provide a
26 covered service because it is contrary to the conscience

1 of the preferred providers, as protected by the Health
2 Care Right of Conscience Act, the issuer shall ensure,
3 directly or indirectly, by terms contained in the payer
4 contract, that the beneficiary will be provided the
5 covered service at no greater cost to the beneficiary than
6 if the service had been provided by a preferred provider.
7 This paragraph (6) does not apply to: (A) a beneficiary
8 who willfully chooses to access a non-preferred provider
9 for health care services available through the panel of
10 preferred providers, or (B) a beneficiary enrolled in a
11 health maintenance organization. In these circumstances,
12 the contractual requirements for non-preferred provider
13 reimbursements shall apply unless Section 356z.3a of the
14 Illinois Insurance Code requires otherwise. In no event
15 shall a beneficiary who receives care at a participating
16 health care facility be required to search for
17 participating providers under the circumstances described
18 in subsection (b) or (b-5) of Section 356z.3a of the
19 Illinois Insurance Code except under the circumstances
20 described in paragraph (2) of subsection (b-5).

21 (7) A provision that the beneficiary shall receive
22 emergency care coverage such that payment for this
23 coverage is not dependent upon whether the emergency
24 services are performed by a preferred or non-preferred
25 provider and the coverage shall be at the same benefit
26 level as if the service or treatment had been rendered by a

1 preferred provider. For purposes of this paragraph (7),
2 "the same benefit level" means that the beneficiary is
3 provided the covered service at no greater cost to the
4 beneficiary than if the service had been provided by a
5 preferred provider. This provision shall be consistent
6 with Section 356z.3a of the Illinois Insurance Code.

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

12 (9) For a network plan to be offered through the
13 Exchange in the individual or small group market, as well
14 as any off-Exchange mirror of such a network plan,
15 evidence that the network plan includes essential
16 community providers in accordance with rules established
17 by the Exchange that will operate in this State for the
18 applicable plan year.

19 (c) The issuer shall demonstrate to the Director a minimum
20 ratio of providers to plan beneficiaries as required by the
21 Department for each network plan.

22 (1) The minimum ratio of physicians or other providers
23 to plan beneficiaries shall be established by the
24 Department in consultation with the Department of Public
25 Health based upon the guidance from the federal Centers
26 for Medicare and Medicaid Services. The Department shall

1 not establish ratios for vision or dental providers who
2 provide services under dental-specific or vision-specific
3 benefits, except to the extent provided under federal law
4 for stand-alone dental plans. The Department shall
5 consider establishing ratios for the following physicians
6 or other providers:

7 (A) Primary Care;

8 (B) Pediatrics;

9 (C) Cardiology;

10 (D) Gastroenterology;

11 (E) General Surgery;

12 (F) Neurology;

13 (G) OB/GYN;

14 (H) Oncology/Radiation;

15 (I) Ophthalmology;

16 (J) Urology;

17 (K) Behavioral Health;

18 (L) Allergy/Immunology;

19 (M) Chiropractic;

20 (N) Dermatology;

21 (O) Endocrinology;

22 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

23 (Q) Infectious Disease;

24 (R) Nephrology;

25 (S) Neurosurgery;

26 (T) Orthopedic Surgery;

- 1 (U) Psychiatry/Rehabilitative;
2 (V) Plastic Surgery;
3 (W) Pulmonary;
4 (X) Rheumatology;
5 (Y) Anesthesiology;
6 (Z) Pain Medicine;
7 (AA) Pediatric Specialty Services;
8 (BB) Outpatient Dialysis; ~~and~~
9 (CC) HIV; ~~and~~
10 (DD) Genetic Medicine and Genetic Counseling.

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

15 (3) Notwithstanding any other law or rule, the minimum
16 ratio for each provider type shall be no less than any such
17 ratio established for qualified health plans in
18 Federally-Facilitated Exchanges by federal law or by the
19 federal Centers for Medicare and Medicaid Services, even
20 if the network plan is issued in the large group market or
21 is otherwise not issued through an exchange. Federal
22 standards for stand-alone dental plans shall only apply to
23 such network plans. In the absence of an applicable
24 Department rule, the federal standards shall apply for the
25 time period specified in the federal law, regulation, or
26 guidance. If the Centers for Medicare and Medicaid

1 Services establish standards that are more stringent than
2 the standards in effect under any Department rule, the
3 Department may amend its rules to conform to the more
4 stringent federal standards.

5 (d) The network plan shall demonstrate to the Director
6 maximum travel and distance standards and appointment wait
7 time standards for plan beneficiaries, which shall be
8 established by the Department in consultation with the
9 Department of Public Health based upon the guidance from the
10 federal Centers for Medicare and Medicaid Services. These
11 standards shall consist of the maximum minutes or miles to be
12 traveled by a plan beneficiary for each county type, such as
13 large counties, metro counties, or rural counties as defined
14 by Department rule.

15 The maximum travel time and distance standards must
16 include standards for each physician and other provider
17 category listed for which ratios have been established.

18 The Director shall establish a process for the review of
19 the adequacy of these standards along with an assessment of
20 additional specialties to be included in the list under this
21 subsection (d).

22 Notwithstanding any other law or Department rule, the
23 maximum travel time and distance standards and appointment
24 wait time standards shall be no greater than any such
25 standards established for qualified health plans in
26 Federally-Facilitated Exchanges by federal law or by the

1 federal Centers for Medicare and Medicaid Services, even if
2 the network plan is issued in the large group market or is
3 otherwise not issued through an exchange. Federal standards
4 for stand-alone dental plans shall only apply to such network
5 plans. In the absence of an applicable Department rule, the
6 federal standards shall apply for the time period specified in
7 the federal law, regulation, or guidance. If the Centers for
8 Medicare and Medicaid Services establish standards that are
9 more stringent than the standards in effect under any
10 Department rule, the Department may amend its rules to conform
11 to the more stringent federal standards.

12 If the federal area designations for the maximum time or
13 distance or appointment wait time standards required are
14 changed by the most recent Letter to Issuers in the
15 Federally-facilitated Marketplaces, the Department shall post
16 on its website notice of such changes and may amend its rules
17 to conform to those designations if the Director deems
18 appropriate.

19 (d-5) (1) Every issuer shall ensure that beneficiaries have
20 timely and proximate access to treatment for mental,
21 emotional, nervous, or substance use disorders or conditions
22 in accordance with the provisions of paragraph (4) of
23 subsection (a) of Section 370c of the Illinois Insurance Code.
24 Issuers shall use a comparable process, strategy, evidentiary
25 standard, and other factors in the development and application
26 of the network adequacy standards for timely and proximate

1 access to treatment for mental, emotional, nervous, or
2 substance use disorders or conditions and those for the access
3 to treatment for medical and surgical conditions. As such, the
4 network adequacy standards for timely and proximate access
5 shall equally be applied to treatment facilities and providers
6 for mental, emotional, nervous, or substance use disorders or
7 conditions and specialists providing medical or surgical
8 benefits pursuant to the parity requirements of Section 370c.1
9 of the Illinois Insurance Code and the federal Paul Wellstone
10 and Pete Domenici Mental Health Parity and Addiction Equity
11 Act of 2008. Notwithstanding the foregoing, the network
12 adequacy standards for timely and proximate access to
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions shall, at a minimum, satisfy the
15 following requirements:

16 (A) For beneficiaries residing in the metropolitan
17 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
18 network adequacy standards for timely and proximate access
19 to treatment for mental, emotional, nervous, or substance
20 use disorders or conditions means a beneficiary shall not
21 have to travel longer than 30 minutes or 30 miles from the
22 beneficiary's residence to receive outpatient treatment
23 for mental, emotional, nervous, or substance use disorders
24 or conditions. Beneficiaries shall not be required to wait
25 longer than 10 business days between requesting an initial
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (B) For beneficiaries residing in Illinois counties
12 other than those counties listed in subparagraph (A) of
13 this paragraph, network adequacy standards for timely and
14 proximate access to treatment for mental, emotional,
15 nervous, or substance use disorders or conditions means a
16 beneficiary shall not have to travel longer than 60
17 minutes or 60 miles from the beneficiary's residence to
18 receive outpatient treatment for mental, emotional,
19 nervous, or substance use disorders or conditions.
20 Beneficiaries shall not be required to wait longer than 10
21 business days between requesting an initial appointment
22 and being seen by the facility or provider of mental,
23 emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment or to wait longer than
25 20 business days between requesting a repeat or follow-up
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment; however, subject to
3 the protections of paragraph (3) of this subsection, a
4 network plan shall not be held responsible if the
5 beneficiary or provider voluntarily chooses to schedule an
6 appointment outside of these required time frames.

7 (2) For beneficiaries residing in all Illinois counties,
8 network adequacy standards for timely and proximate access to
9 treatment for mental, emotional, nervous, or substance use
10 disorders or conditions means a beneficiary shall not have to
11 travel longer than 60 minutes or 60 miles from the
12 beneficiary's residence to receive inpatient or residential
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions.

15 (3) If there is no in-network facility or provider
16 available for a beneficiary to receive timely and proximate
17 access to treatment for mental, emotional, nervous, or
18 substance use disorders or conditions in accordance with the
19 network adequacy standards outlined in this subsection, the
20 issuer shall provide necessary exceptions to its network to
21 ensure admission and treatment with a provider or at a
22 treatment facility in accordance with the network adequacy
23 standards in this subsection.

24 (4) If the federal Centers for Medicare and Medicaid
25 Services establishes or law requires more stringent standards
26 for qualified health plans in the Federally-Facilitated

1 Exchanges, the federal standards shall control for all network
2 plans for the time period specified in the federal law,
3 regulation, or guidance, even if the network plan is issued in
4 the large group market, is issued through a different type of
5 Exchange, or is otherwise not issued through an Exchange.

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

9 (f) The network plan may consider use of other health care
10 service delivery options, such as telemedicine or telehealth,
11 mobile clinics, and centers of excellence, or other ways of
12 delivering care to partially meet the requirements set under
13 this Section.

14 (g) Except for the requirements set forth in subsection
15 (d-5), issuers who are not able to comply with the provider
16 ratios and time and distance or appointment wait time
17 standards established under this Act or federal law may
18 request an exception to these requirements from the
19 Department. The Department may grant an exception in the
20 following circumstances:

21 (1) if no providers or facilities meet the specific
22 time and distance standard in a specific service area and
23 the issuer (i) discloses information on the distance and
24 travel time points that beneficiaries would have to travel
25 beyond the required criterion to reach the next closest
26 contracted provider outside of the service area and (ii)

1 provides contact information, including names, addresses,
2 and phone numbers for the next closest contracted provider
3 or facility;

4 (2) if patterns of care in the service area do not
5 support the need for the requested number of provider or
6 facility type and the issuer provides data on local
7 patterns of care, such as claims data, referral patterns,
8 or local provider interviews, indicating where the
9 beneficiaries currently seek this type of care or where
10 the physicians currently refer beneficiaries, or both; or

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

13 (h) Issuers are required to report to the Director any
14 material change to an approved network plan within 15 business
15 days after the change occurs and any change that would result
16 in failure to meet the requirements of this Act. The issuer
17 shall submit a revised version of the portions of the network
18 adequacy filing affected by the material change, as determined
19 by the Director by rule, and the issuer shall attach versions
20 with the changes indicated for each document that was revised
21 from the previous version of the filing. Upon notice from the
22 issuer, the Director shall reevaluate the network plan's
23 compliance with the network adequacy and transparency
24 standards of this Act. For every day past 15 business days that
25 the issuer fails to submit a revised network adequacy filing
26 to the Director, the Director may order a fine of \$5,000 per

1 day.

2 (i) If a network plan is inadequate under this Act with
3 respect to a provider type in a county, and if the network plan
4 does not have an approved exception for that provider type in
5 that county pursuant to subsection (g), an issuer shall cover
6 out-of-network claims for covered health care services
7 received from that provider type within that county at the
8 in-network benefit level and shall retroactively adjudicate
9 and reimburse beneficiaries to achieve that objective if their
10 claims were processed at the out-of-network level contrary to
11 this subsection. Nothing in this subsection shall be construed
12 to supersede Section 356z.3a of the Illinois Insurance Code.

13 (j) If the Director determines that a network is
14 inadequate in any county and no exception has been granted
15 under subsection (g) and the issuer does not have a process in
16 place to comply with subsection (d-5), the Director may
17 prohibit the network plan from being issued or renewed within
18 that county until the Director determines that the network is
19 adequate apart from processes and exceptions described in
20 subsections (d-5) and (g). Nothing in this subsection shall be
21 construed to terminate any beneficiary's health insurance
22 coverage under a network plan before the expiration of the
23 beneficiary's policy period if the Director makes a
24 determination under this subsection after the issuance or
25 renewal of the beneficiary's policy or certificate because of
26 a material change. Policies or certificates issued or renewed

1 in violation of this subsection may subject the issuer to a
2 civil penalty of \$5,000 per policy.

3 (k) For the Department to enforce any new or modified
4 federal standard before the Department adopts the standard by
5 rule, the Department must, no later than May 15 before the
6 start of the plan year, give public notice to the affected
7 health insurance issuers through a bulletin.

8 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
9 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

10 (Text of Section from P.A. 103-656)

11 Sec. 10. Network adequacy.

12 (a) An insurer providing a network plan shall file a
13 description of all of the following with the Director:

14 (1) The written policies and procedures for adding
15 providers to meet patient needs based on increases in the
16 number of beneficiaries, changes in the
17 patient-to-provider ratio, changes in medical and health
18 care capabilities, and increased demand for services.

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

21 (3) The written policies and procedures on how the
22 network plan will provide 24-hour, 7-day per week access
23 to network-affiliated primary care, emergency services,
24 and women's principal health care providers.

25 An insurer shall not prohibit a preferred provider from

1 discussing any specific or all treatment options with
2 beneficiaries irrespective of the insurer's position on those
3 treatment options or from advocating on behalf of
4 beneficiaries within the utilization review, grievance, or
5 appeals processes established by the insurer in accordance
6 with any rights or remedies available under applicable State
7 or federal law.

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

11 (1) A geographic map of the area proposed to be served
12 by the plan by county service area and zip code, including
13 marked locations for preferred providers.

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

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

20 (4) An Internet website and toll-free telephone number
21 for beneficiaries and prospective beneficiaries to access
22 current and accurate lists of preferred providers,
23 additional information about the plan, as well as any
24 other information required by Department rule.

25 (5) A description of how health care services to be
26 rendered under the network plan are reasonably accessible

1 and available to beneficiaries. The description shall
2 address all of the following:

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

5 (B) the ratio of physicians and other providers to
6 beneficiaries, by specialty and including primary care
7 physicians and facility-based physicians when
8 applicable under the contract, necessary to meet the
9 health care needs and service demands of the currently
10 enrolled population;

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

13 (D) a description of how the use of telemedicine,
14 telehealth, or mobile care services may be used to
15 partially meet the network adequacy standards, if
16 applicable.

17 (6) A provision ensuring that whenever a beneficiary
18 has made a good faith effort, as evidenced by accessing
19 the provider directory, calling the network plan, and
20 calling the provider, to utilize preferred providers for a
21 covered service and it is determined the insurer does not
22 have the appropriate preferred providers due to
23 insufficient number, type, unreasonable travel distance or
24 delay, or preferred providers refusing to provide a
25 covered service because it is contrary to the conscience
26 of the preferred providers, as protected by the Health

1 Care Right of Conscience Act, the insurer shall ensure,
2 directly or indirectly, by terms contained in the payer
3 contract, that the beneficiary will be provided the
4 covered service at no greater cost to the beneficiary than
5 if the service had been provided by a preferred provider.
6 This paragraph (6) does not apply to: (A) a beneficiary
7 who willfully chooses to access a non-preferred provider
8 for health care services available through the panel of
9 preferred providers, or (B) a beneficiary enrolled in a
10 health maintenance organization. In these circumstances,
11 the contractual requirements for non-preferred provider
12 reimbursements shall apply unless Section 356z.3a of the
13 Illinois Insurance Code requires otherwise. In no event
14 shall a beneficiary who receives care at a participating
15 health care facility be required to search for
16 participating providers under the circumstances described
17 in subsection (b) or (b-5) of Section 356z.3a of the
18 Illinois Insurance Code except under the circumstances
19 described in paragraph (2) of subsection (b-5).

20 (7) A provision that the beneficiary shall receive
21 emergency care coverage such that payment for this
22 coverage is not dependent upon whether the emergency
23 services are performed by a preferred or non-preferred
24 provider and the coverage shall be at the same benefit
25 level as if the service or treatment had been rendered by a
26 preferred provider. For purposes of this paragraph (7),

1 "the same benefit level" means that the beneficiary is
2 provided the covered service at no greater cost to the
3 beneficiary than if the service had been provided by a
4 preferred provider. This provision shall be consistent
5 with Section 356z.3a of the Illinois Insurance Code.

6 (8) A limitation that complies with subsections (d)
7 and (e) of Section 55 of the Prior Authorization Reform
8 Act.

9 (c) The network plan shall demonstrate to the Director a
10 minimum ratio of providers to plan beneficiaries as required
11 by the Department.

12 (1) The ratio of physicians or other providers to plan
13 beneficiaries shall be established annually by the
14 Department in consultation with the Department of Public
15 Health based upon the guidance from the federal Centers
16 for Medicare and Medicaid Services. The Department shall
17 not establish ratios for vision or dental providers who
18 provide services under dental-specific or vision-specific
19 benefits. The Department shall consider establishing
20 ratios for the following physicians or other providers:

21 (A) Primary Care;

22 (B) Pediatrics;

23 (C) Cardiology;

24 (D) Gastroenterology;

25 (E) General Surgery;

26 (F) Neurology;

- 1 (G) OB/GYN;
2 (H) Oncology/Radiation;
3 (I) Ophthalmology;
4 (J) Urology;
5 (K) Behavioral Health;
6 (L) Allergy/Immunology;
7 (M) Chiropractic;
8 (N) Dermatology;
9 (O) Endocrinology;
10 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
11 (Q) Infectious Disease;
12 (R) Nephrology;
13 (S) Neurosurgery;
14 (T) Orthopedic Surgery;
15 (U) Physiatry/Rehabilitative;
16 (V) Plastic Surgery;
17 (W) Pulmonary;
18 (X) Rheumatology;
19 (Y) Anesthesiology;
20 (Z) Pain Medicine;
21 (AA) Pediatric Specialty Services;
22 (BB) Outpatient Dialysis; ~~and~~
23 (CC) HIV; ~~and~~
24 (DD) Genetic Medicine and Genetic Counseling.

25 (2) The Director shall establish a process for the
26 review of the adequacy of these standards, along with an

1 assessment of additional specialties to be included in the
2 list under this subsection (c).

3 (d) The network plan shall demonstrate to the Director
4 maximum travel and distance standards for plan beneficiaries,
5 which shall be established annually by the Department in
6 consultation with the Department of Public Health based upon
7 the guidance from the federal Centers for Medicare and
8 Medicaid Services. These standards shall consist of the
9 maximum minutes or miles to be traveled by a plan beneficiary
10 for each county type, such as large counties, metro counties,
11 or rural counties as defined by Department rule.

12 The maximum travel time and distance standards must
13 include standards for each physician and other provider
14 category listed for which ratios have been established.

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

19 (d-5)(1) Every insurer shall ensure that beneficiaries
20 have timely and proximate access to treatment for mental,
21 emotional, nervous, or substance use disorders or conditions
22 in accordance with the provisions of paragraph (4) of
23 subsection (a) of Section 370c of the Illinois Insurance Code.
24 Insurers shall use a comparable process, strategy, evidentiary
25 standard, and other factors in the development and application
26 of the network adequacy standards for timely and proximate

1 access to treatment for mental, emotional, nervous, or
2 substance use disorders or conditions and those for the access
3 to treatment for medical and surgical conditions. As such, the
4 network adequacy standards for timely and proximate access
5 shall equally be applied to treatment facilities and providers
6 for mental, emotional, nervous, or substance use disorders or
7 conditions and specialists providing medical or surgical
8 benefits pursuant to the parity requirements of Section 370c.1
9 of the Illinois Insurance Code and the federal Paul Wellstone
10 and Pete Domenici Mental Health Parity and Addiction Equity
11 Act of 2008. Notwithstanding the foregoing, the network
12 adequacy standards for timely and proximate access to
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions shall, at a minimum, satisfy the
15 following requirements:

16 (A) For beneficiaries residing in the metropolitan
17 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
18 network adequacy standards for timely and proximate access
19 to treatment for mental, emotional, nervous, or substance
20 use disorders or conditions means a beneficiary shall not
21 have to travel longer than 30 minutes or 30 miles from the
22 beneficiary's residence to receive outpatient treatment
23 for mental, emotional, nervous, or substance use disorders
24 or conditions. Beneficiaries shall not be required to wait
25 longer than 10 business days between requesting an initial
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (B) For beneficiaries residing in Illinois counties
12 other than those counties listed in subparagraph (A) of
13 this paragraph, network adequacy standards for timely and
14 proximate access to treatment for mental, emotional,
15 nervous, or substance use disorders or conditions means a
16 beneficiary shall not have to travel longer than 60
17 minutes or 60 miles from the beneficiary's residence to
18 receive outpatient treatment for mental, emotional,
19 nervous, or substance use disorders or conditions.
20 Beneficiaries shall not be required to wait longer than 10
21 business days between requesting an initial appointment
22 and being seen by the facility or provider of mental,
23 emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment or to wait longer than
25 20 business days between requesting a repeat or follow-up
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment; however, subject to
3 the protections of paragraph (3) of this subsection, a
4 network plan shall not be held responsible if the
5 beneficiary or provider voluntarily chooses to schedule an
6 appointment outside of these required time frames.

7 (2) For beneficiaries residing in all Illinois counties,
8 network adequacy standards for timely and proximate access to
9 treatment for mental, emotional, nervous, or substance use
10 disorders or conditions means a beneficiary shall not have to
11 travel longer than 60 minutes or 60 miles from the
12 beneficiary's residence to receive inpatient or residential
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions.

15 (3) If there is no in-network facility or provider
16 available for a beneficiary to receive timely and proximate
17 access to treatment for mental, emotional, nervous, or
18 substance use disorders or conditions in accordance with the
19 network adequacy standards outlined in this subsection, the
20 insurer shall provide necessary exceptions to its network to
21 ensure admission and treatment with a provider or at a
22 treatment facility in accordance with the network adequacy
23 standards in this subsection.

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

1 (f) The network plan may consider use of other health care
2 service delivery options, such as telemedicine or telehealth,
3 mobile clinics, and centers of excellence, or other ways of
4 delivering care to partially meet the requirements set under
5 this Section.

6 (g) Except for the requirements set forth in subsection
7 (d-5), insurers who are not able to comply with the provider
8 ratios and time and distance standards established by the
9 Department may request an exception to these requirements from
10 the Department. The Department may grant an exception in the
11 following circumstances:

12 (1) if no providers or facilities meet the specific
13 time and distance standard in a specific service area and
14 the insurer (i) discloses information on the distance and
15 travel time points that beneficiaries would have to travel
16 beyond the required criterion to reach the next closest
17 contracted provider outside of the service area and (ii)
18 provides contact information, including names, addresses,
19 and phone numbers for the next closest contracted provider
20 or facility;

21 (2) if patterns of care in the service area do not
22 support the need for the requested number of provider or
23 facility type and the insurer provides data on local
24 patterns of care, such as claims data, referral patterns,
25 or local provider interviews, indicating where the
26 beneficiaries currently seek this type of care or where

1 the physicians currently refer beneficiaries, or both; or
2 (3) other circumstances deemed appropriate by the
3 Department consistent with the requirements of this Act.

4 (h) Insurers are required to report to the Director any
5 material change to an approved network plan within 15 days
6 after the change occurs and any change that would result in
7 failure to meet the requirements of this Act. Upon notice from
8 the insurer, the Director shall reevaluate the network plan's
9 compliance with the network adequacy and transparency
10 standards of this Act.

11 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
12 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

13 (Text of Section from P.A. 103-718)

14 Sec. 10. Network adequacy.

15 (a) An insurer providing a network plan shall file a
16 description of all of the following with the Director:

17 (1) The written policies and procedures for adding
18 providers to meet patient needs based on increases in the
19 number of beneficiaries, changes in the
20 patient-to-provider ratio, changes in medical and health
21 care capabilities, and increased demand for services.

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

24 (3) The written policies and procedures on how the
25 network plan will provide 24-hour, 7-day per week access

1 to network-affiliated primary care, emergency services,
2 and obstetrical and gynecological health care
3 professionals.

4 An insurer shall not prohibit a preferred provider from
5 discussing any specific or all treatment options with
6 beneficiaries irrespective of the insurer's position on those
7 treatment options or from advocating on behalf of
8 beneficiaries within the utilization review, grievance, or
9 appeals processes established by the insurer in accordance
10 with any rights or remedies available under applicable State
11 or federal law.

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

15 (1) A geographic map of the area proposed to be served
16 by the plan by county service area and zip code, including
17 marked locations for preferred providers.

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

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

24 (4) An Internet website and toll-free telephone number
25 for beneficiaries and prospective beneficiaries to access
26 current and accurate lists of preferred providers,

1 additional information about the plan, as well as any
2 other information required by Department rule.

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

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

9 (B) the ratio of physicians and other providers to
10 beneficiaries, by specialty and including primary care
11 physicians and facility-based physicians when
12 applicable under the contract, necessary to meet the
13 health care needs and service demands of the currently
14 enrolled population;

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

17 (D) a description of how the use of telemedicine,
18 telehealth, or mobile care services may be used to
19 partially meet the network adequacy standards, if
20 applicable.

21 (6) A provision ensuring that whenever a beneficiary
22 has made a good faith effort, as evidenced by accessing
23 the provider directory, calling the network plan, and
24 calling the provider, to utilize preferred providers for a
25 covered service and it is determined the insurer does not
26 have the appropriate preferred providers due to

1 insufficient number, type, unreasonable travel distance or
2 delay, or preferred providers refusing to provide a
3 covered service because it is contrary to the conscience
4 of the preferred providers, as protected by the Health
5 Care Right of Conscience Act, the insurer shall ensure,
6 directly or indirectly, by terms contained in the payer
7 contract, that the beneficiary will be provided the
8 covered service at no greater cost to the beneficiary than
9 if the service had been provided by a preferred provider.
10 This paragraph (6) does not apply to: (A) a beneficiary
11 who willfully chooses to access a non-preferred provider
12 for health care services available through the panel of
13 preferred providers, or (B) a beneficiary enrolled in a
14 health maintenance organization. In these circumstances,
15 the contractual requirements for non-preferred provider
16 reimbursements shall apply unless Section 356z.3a of the
17 Illinois Insurance Code requires otherwise. In no event
18 shall a beneficiary who receives care at a participating
19 health care facility be required to search for
20 participating providers under the circumstances described
21 in subsection (b) or (b-5) of Section 356z.3a of the
22 Illinois Insurance Code except under the circumstances
23 described in paragraph (2) of subsection (b-5).

24 (7) A provision that the beneficiary shall receive
25 emergency care coverage such that payment for this
26 coverage is not dependent upon whether the emergency

1 services are performed by a preferred or non-preferred
2 provider and the coverage shall be at the same benefit
3 level as if the service or treatment had been rendered by a
4 preferred provider. For purposes of this paragraph (7),
5 "the same benefit level" means that the beneficiary is
6 provided the covered service at no greater cost to the
7 beneficiary than if the service had been provided by a
8 preferred provider. This provision shall be consistent
9 with Section 356z.3a of the Illinois Insurance Code.

10 (8) A limitation that, if the plan provides that the
11 beneficiary will incur a penalty for failing to
12 pre-certify inpatient hospital treatment, the penalty may
13 not exceed \$1,000 per occurrence in addition to the plan
14 cost-sharing provisions.

15 (c) The network plan shall demonstrate to the Director a
16 minimum ratio of providers to plan beneficiaries as required
17 by the Department.

18 (1) The ratio of physicians or other providers to plan
19 beneficiaries shall be established annually by the
20 Department in consultation with the Department of Public
21 Health based upon the guidance from the federal Centers
22 for Medicare and Medicaid Services. The Department shall
23 not establish ratios for vision or dental providers who
24 provide services under dental-specific or vision-specific
25 benefits. The Department shall consider establishing
26 ratios for the following physicians or other providers:

- 1 (A) Primary Care;
- 2 (B) Pediatrics;
- 3 (C) Cardiology;
- 4 (D) Gastroenterology;
- 5 (E) General Surgery;
- 6 (F) Neurology;
- 7 (G) OB/GYN;
- 8 (H) Oncology/Radiation;
- 9 (I) Ophthalmology;
- 10 (J) Urology;
- 11 (K) Behavioral Health;
- 12 (L) Allergy/Immunology;
- 13 (M) Chiropractic;
- 14 (N) Dermatology;
- 15 (O) Endocrinology;
- 16 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- 17 (Q) Infectious Disease;
- 18 (R) Nephrology;
- 19 (S) Neurosurgery;
- 20 (T) Orthopedic Surgery;
- 21 (U) Physiatry/Rehabilitative;
- 22 (V) Plastic Surgery;
- 23 (W) Pulmonary;
- 24 (X) Rheumatology;
- 25 (Y) Anesthesiology;
- 26 (Z) Pain Medicine;

- 1 (AA) Pediatric Specialty Services;
2 (BB) Outpatient Dialysis; ~~and~~
3 (CC) HIV; ~~and~~
4 (DD) Genetic Medicine and Genetic Counseling.

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

9 (d) The network plan shall demonstrate to the Director
10 maximum travel and distance standards for plan beneficiaries,
11 which shall be established annually by the Department in
12 consultation with the Department of Public Health based upon
13 the guidance from the federal Centers for Medicare and
14 Medicaid Services. These standards shall consist of the
15 maximum minutes or miles to be traveled by a plan beneficiary
16 for each county type, such as large counties, metro counties,
17 or rural counties as defined by Department rule.

18 The maximum travel time and distance standards must
19 include standards for each physician and other provider
20 category listed for which ratios have been established.

21 The Director shall establish a process for the review of
22 the adequacy of these standards along with an assessment of
23 additional specialties to be included in the list under this
24 subsection (d).

25 (d-5)(1) Every insurer shall ensure that beneficiaries
26 have timely and proximate access to treatment for mental,

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

22 (A) For beneficiaries residing in the metropolitan
23 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
24 network adequacy standards for timely and proximate access
25 to treatment for mental, emotional, nervous, or substance
26 use disorders or conditions means a beneficiary shall not

1 have to travel longer than 30 minutes or 30 miles from the
2 beneficiary's residence to receive outpatient treatment
3 for mental, emotional, nervous, or substance use disorders
4 or conditions. Beneficiaries shall not be required to wait
5 longer than 10 business days between requesting an initial
6 appointment and being seen by the facility or provider of
7 mental, emotional, nervous, or substance use disorders or
8 conditions for outpatient treatment or to wait longer than
9 20 business days between requesting a repeat or follow-up
10 appointment and being seen by the facility or provider of
11 mental, emotional, nervous, or substance use disorders or
12 conditions for outpatient treatment; however, subject to
13 the protections of paragraph (3) of this subsection, a
14 network plan shall not be held responsible if the
15 beneficiary or provider voluntarily chooses to schedule an
16 appointment outside of these required time frames.

17 (B) For beneficiaries residing in Illinois counties
18 other than those counties listed in subparagraph (A) of
19 this paragraph, network adequacy standards for timely and
20 proximate access to treatment for mental, emotional,
21 nervous, or substance use disorders or conditions means a
22 beneficiary shall not have to travel longer than 60
23 minutes or 60 miles from the beneficiary's residence to
24 receive outpatient treatment for mental, emotional,
25 nervous, or substance use disorders or conditions.
26 Beneficiaries shall not be required to wait longer than 10

1 business days between requesting an initial appointment
2 and being seen by the facility or provider of mental,
3 emotional, nervous, or substance use disorders or
4 conditions for outpatient treatment or to wait longer than
5 20 business days between requesting a repeat or follow-up
6 appointment and being seen by the facility or provider of
7 mental, emotional, nervous, or substance use disorders or
8 conditions for outpatient treatment; however, subject to
9 the protections of paragraph (3) of this subsection, a
10 network plan shall not be held responsible if the
11 beneficiary or provider voluntarily chooses to schedule an
12 appointment outside of these required time frames.

13 (2) For beneficiaries residing in all Illinois counties,
14 network adequacy standards for timely and proximate access to
15 treatment for mental, emotional, nervous, or substance use
16 disorders or conditions means a beneficiary shall not have to
17 travel longer than 60 minutes or 60 miles from the
18 beneficiary's residence to receive inpatient or residential
19 treatment for mental, emotional, nervous, or substance use
20 disorders or conditions.

21 (3) If there is no in-network facility or provider
22 available for a beneficiary to receive timely and proximate
23 access to treatment for mental, emotional, nervous, or
24 substance use disorders or conditions in accordance with the
25 network adequacy standards outlined in this subsection, the
26 insurer shall provide necessary exceptions to its network to

1 ensure admission and treatment with a provider or at a
2 treatment facility in accordance with the network adequacy
3 standards in this subsection.

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

7 (f) The network plan may consider use of other health care
8 service delivery options, such as telemedicine or telehealth,
9 mobile clinics, and centers of excellence, or other ways of
10 delivering care to partially meet the requirements set under
11 this Section.

12 (g) Except for the requirements set forth in subsection
13 (d-5), insurers who are not able to comply with the provider
14 ratios and time and distance standards established by the
15 Department may request an exception to these requirements from
16 the Department. The Department may grant an exception in the
17 following circumstances:

18 (1) if no providers or facilities meet the specific
19 time and distance standard in a specific service area and
20 the insurer (i) discloses information on the distance and
21 travel time points that beneficiaries would have to travel
22 beyond the required criterion to reach the next closest
23 contracted provider outside of the service area and (ii)
24 provides contact information, including names, addresses,
25 and phone numbers for the next closest contracted provider
26 or facility;

1 (2) if patterns of care in the service area do not
2 support the need for the requested number of provider or
3 facility type and the insurer provides data on local
4 patterns of care, such as claims data, referral patterns,
5 or local provider interviews, indicating where the
6 beneficiaries currently seek this type of care or where
7 the physicians currently refer beneficiaries, or both; or

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

10 (h) Insurers are required to report to the Director any
11 material change to an approved network plan within 15 days
12 after the change occurs and any change that would result in
13 failure to meet the requirements of this Act. Upon notice from
14 the insurer, the Director shall reevaluate the network plan's
15 compliance with the network adequacy and transparency
16 standards of this Act.

17 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
18 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

19 (Text of Section from P.A. 103-777)

20 Sec. 10. Network adequacy.

21 (a) An insurer providing a network plan shall file a
22 description of all of the following with the Director:

23 (1) The written policies and procedures for adding
24 providers to meet patient needs based on increases in the
25 number of beneficiaries, changes in the

1 patient-to-provider ratio, changes in medical and health
2 care capabilities, and increased demand for services.

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

5 (3) The written policies and procedures on how the
6 network plan will provide 24-hour, 7-day per week access
7 to network-affiliated primary care, emergency services,
8 and women's principal health care providers.

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

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

20 (1) A geographic map of the area proposed to be served
21 by the plan by county service area and zip code, including
22 marked locations for preferred providers.

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

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

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

8 (5) A description of how health care services to be
9 rendered under the network plan are reasonably accessible
10 and available to beneficiaries. The description shall
11 address all of the following:

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

14 (B) the ratio of physicians and other providers to
15 beneficiaries, by specialty and including primary care
16 physicians and facility-based physicians when
17 applicable under the contract, necessary to meet the
18 health care needs and service demands of the currently
19 enrolled population;

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

22 (D) a description of how the use of telemedicine,
23 telehealth, or mobile care services may be used to
24 partially meet the network adequacy standards, if
25 applicable.

26 (6) A provision ensuring that whenever a beneficiary

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

1 Illinois Insurance Code except under the circumstances
2 described in paragraph (2) of subsection (b-5).

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

15 (8) A limitation that, if the plan provides that the
16 beneficiary will incur a penalty for failing to
17 pre-certify inpatient hospital treatment, the penalty may
18 not exceed \$1,000 per occurrence in addition to the plan
19 cost sharing provisions.

20 (c) The network plan shall demonstrate to the Director a
21 minimum ratio of providers to plan beneficiaries as required
22 by the Department.

23 (1) The ratio of physicians or other providers to plan
24 beneficiaries shall be established annually by the
25 Department in consultation with the Department of Public
26 Health based upon the guidance from the federal Centers

1 for Medicare and Medicaid Services. The Department shall
2 not establish ratios for vision or dental providers who
3 provide services under dental-specific or vision-specific
4 benefits, except to the extent provided under federal law
5 for stand-alone dental plans. The Department shall
6 consider establishing ratios for the following physicians
7 or other providers:

8 (A) Primary Care;

9 (B) Pediatrics;

10 (C) Cardiology;

11 (D) Gastroenterology;

12 (E) General Surgery;

13 (F) Neurology;

14 (G) OB/GYN;

15 (H) Oncology/Radiation;

16 (I) Ophthalmology;

17 (J) Urology;

18 (K) Behavioral Health;

19 (L) Allergy/Immunology;

20 (M) Chiropractic;

21 (N) Dermatology;

22 (O) Endocrinology;

23 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

24 (Q) Infectious Disease;

25 (R) Nephrology;

26 (S) Neurosurgery;

1 (T) Orthopedic Surgery;
2 (U) Physiatry/Rehabilitative;
3 (V) Plastic Surgery;
4 (W) Pulmonary;
5 (X) Rheumatology;
6 (Y) Anesthesiology;
7 (Z) Pain Medicine;
8 (AA) Pediatric Specialty Services;
9 (BB) Outpatient Dialysis; ~~and~~
10 (CC) HIV; ~~and~~
11 (DD) Genetic Medicine and Genetic Counseling.

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

16 (3) If the federal Centers for Medicare and Medicaid
17 Services establishes minimum provider ratios for
18 stand-alone dental plans in the type of exchange in use in
19 this State for a given plan year, the Department shall
20 enforce those standards for stand-alone dental plans for
21 that plan year.

22 (d) The network plan shall demonstrate to the Director
23 maximum travel and distance standards for plan beneficiaries,
24 which shall be established annually by the Department in
25 consultation with the Department of Public Health based upon
26 the guidance from the federal Centers for Medicare and

1 Medicaid Services. These standards shall consist of the
2 maximum minutes or miles to be traveled by a plan beneficiary
3 for each county type, such as large counties, metro counties,
4 or rural counties as defined by Department rule.

5 The maximum travel time and distance standards must
6 include standards for each physician and other provider
7 category listed for which ratios have been established.

8 The Director shall establish a process for the review of
9 the adequacy of these standards along with an assessment of
10 additional specialties to be included in the list under this
11 subsection (d).

12 If the federal Centers for Medicare and Medicaid Services
13 establishes appointment wait-time standards for qualified
14 health plans, including stand-alone dental plans, in the type
15 of exchange in use in this State for a given plan year, the
16 Department shall enforce those standards for the same types of
17 qualified health plans for that plan year. If the federal
18 Centers for Medicare and Medicaid Services establishes time
19 and distance standards for stand-alone dental plans in the
20 type of exchange in use in this State for a given plan year,
21 the Department shall enforce those standards for stand-alone
22 dental plans for that plan year.

23 (d-5)(1) Every insurer shall ensure that beneficiaries
24 have timely and proximate access to treatment for mental,
25 emotional, nervous, or substance use disorders or conditions
26 in accordance with the provisions of paragraph (4) of

1 subsection (a) of Section 370c of the Illinois Insurance Code.
2 Insurers shall use a comparable process, strategy, evidentiary
3 standard, and other factors in the development and application
4 of the network adequacy standards for timely and proximate
5 access to treatment for mental, emotional, nervous, or
6 substance use disorders or conditions and those for the access
7 to treatment for medical and surgical conditions. As such, the
8 network adequacy standards for timely and proximate access
9 shall equally be applied to treatment facilities and providers
10 for mental, emotional, nervous, or substance use disorders or
11 conditions and specialists providing medical or surgical
12 benefits pursuant to the parity requirements of Section 370c.1
13 of the Illinois Insurance Code and the federal Paul Wellstone
14 and Pete Domenici Mental Health Parity and Addiction Equity
15 Act of 2008. Notwithstanding the foregoing, the network
16 adequacy standards for timely and proximate access to
17 treatment for mental, emotional, nervous, or substance use
18 disorders or conditions shall, at a minimum, satisfy the
19 following requirements:

20 (A) For beneficiaries residing in the metropolitan
21 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
22 network adequacy standards for timely and proximate access
23 to treatment for mental, emotional, nervous, or substance
24 use disorders or conditions means a beneficiary shall not
25 have to travel longer than 30 minutes or 30 miles from the
26 beneficiary's residence to receive outpatient treatment

1 for mental, emotional, nervous, or substance use disorders
2 or conditions. Beneficiaries shall not be required to wait
3 longer than 10 business days between requesting an initial
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment or to wait longer than
7 20 business days between requesting a repeat or follow-up
8 appointment and being seen by the facility or provider of
9 mental, emotional, nervous, or substance use disorders or
10 conditions for outpatient treatment; however, subject to
11 the protections of paragraph (3) of this subsection, a
12 network plan shall not be held responsible if the
13 beneficiary or provider voluntarily chooses to schedule an
14 appointment outside of these required time frames.

15 (B) For beneficiaries residing in Illinois counties
16 other than those counties listed in subparagraph (A) of
17 this paragraph, network adequacy standards for timely and
18 proximate access to treatment for mental, emotional,
19 nervous, or substance use disorders or conditions means a
20 beneficiary shall not have to travel longer than 60
21 minutes or 60 miles from the beneficiary's residence to
22 receive outpatient treatment for mental, emotional,
23 nervous, or substance use disorders or conditions.
24 Beneficiaries shall not be required to wait longer than 10
25 business days between requesting an initial appointment
26 and being seen by the facility or provider of mental,

1 emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (2) For beneficiaries residing in all Illinois counties,
12 network adequacy standards for timely and proximate access to
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions means a beneficiary shall not have to
15 travel longer than 60 minutes or 60 miles from the
16 beneficiary's residence to receive inpatient or residential
17 treatment for mental, emotional, nervous, or substance use
18 disorders or conditions.

19 (3) If there is no in-network facility or provider
20 available for a beneficiary to receive timely and proximate
21 access to treatment for mental, emotional, nervous, or
22 substance use disorders or conditions in accordance with the
23 network adequacy standards outlined in this subsection, the
24 insurer shall provide necessary exceptions to its network to
25 ensure admission and treatment with a provider or at a
26 treatment facility in accordance with the network adequacy

1 standards in this subsection.

2 (4) If the federal Centers for Medicare and Medicaid
3 Services establishes a more stringent standard in any county
4 than specified in paragraph (1) or (2) of this subsection
5 (d-5) for qualified health plans in the type of exchange in use
6 in this State for a given plan year, the federal standard shall
7 apply in lieu of the standard in paragraph (1) or (2) of this
8 subsection (d-5) for qualified health plans for that plan
9 year.

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

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

18 (g) Except for the requirements set forth in subsection
19 (d-5), insurers who are not able to comply with the provider
20 ratios, time and distance standards, and appointment wait-time
21 standards established under this Act or federal law may
22 request an exception to these requirements from the
23 Department. The Department may grant an exception in the
24 following circumstances:

25 (1) if no providers or facilities meet the specific
26 time and distance standard in a specific service area and

1 the insurer (i) discloses information on the distance and
2 travel time points that beneficiaries would have to travel
3 beyond the required criterion to reach the next closest
4 contracted provider outside of the service area and (ii)
5 provides contact information, including names, addresses,
6 and phone numbers for the next closest contracted provider
7 or facility;

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

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

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

24 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
25 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

1 (Text of Section from P.A. 103-906)

2 Sec. 10. Network adequacy.

3 (a) An insurer providing a network plan shall file a
4 description of all of the following with the Director:

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

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

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

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

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

1 (1) A geographic map of the area proposed to be served
2 by the plan by county service area and zip code, including
3 marked locations for preferred providers.

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

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

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

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

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

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

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

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

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

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

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

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

1 (c) The network plan shall demonstrate to the Director a
2 minimum ratio of providers to plan beneficiaries as required
3 by the Department.

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

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

- 1 (O) Endocrinology;
- 2 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- 3 (Q) Infectious Disease;
- 4 (R) Nephrology;
- 5 (S) Neurosurgery;
- 6 (T) Orthopedic Surgery;
- 7 (U) Physiatry/Rehabilitative;
- 8 (V) Plastic Surgery;
- 9 (W) Pulmonary;
- 10 (X) Rheumatology;
- 11 (Y) Anesthesiology;
- 12 (Z) Pain Medicine;
- 13 (AA) Pediatric Specialty Services;
- 14 (BB) Outpatient Dialysis; ~~and~~
- 15 (CC) HIV; ~~and-~~
- 16 (DD) Genetic Medicine and Genetic Counseling.

17 (1.5) Beginning January 1, 2026, every insurer shall
18 demonstrate to the Director that each in-network hospital
19 has at least one radiologist, pathologist,
20 anesthesiologist, and emergency room physician as a
21 preferred provider in a network plan. The Department may,
22 by rule, require additional types of hospital-based
23 medical specialists to be included as preferred providers
24 in each in-network hospital in a network plan.

25 (2) The Director shall establish a process for the
26 review of the adequacy of these standards, along with an

1 assessment of additional specialties to be included in the
2 list under this subsection (c).

3 (d) The network plan shall demonstrate to the Director
4 maximum travel and distance standards for plan beneficiaries,
5 which shall be established annually by the Department in
6 consultation with the Department of Public Health based upon
7 the guidance from the federal Centers for Medicare and
8 Medicaid Services. These standards shall consist of the
9 maximum minutes or miles to be traveled by a plan beneficiary
10 for each county type, such as large counties, metro counties,
11 or rural counties as defined by Department rule.

12 The maximum travel time and distance standards must
13 include standards for each physician and other provider
14 category listed for which ratios have been established.

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

19 (d-5)(1) Every insurer shall ensure that beneficiaries
20 have timely and proximate access to treatment for mental,
21 emotional, nervous, or substance use disorders or conditions
22 in accordance with the provisions of paragraph (4) of
23 subsection (a) of Section 370c of the Illinois Insurance Code.
24 Insurers shall use a comparable process, strategy, evidentiary
25 standard, and other factors in the development and application
26 of the network adequacy standards for timely and proximate

1 access to treatment for mental, emotional, nervous, or
2 substance use disorders or conditions and those for the access
3 to treatment for medical and surgical conditions. As such, the
4 network adequacy standards for timely and proximate access
5 shall equally be applied to treatment facilities and providers
6 for mental, emotional, nervous, or substance use disorders or
7 conditions and specialists providing medical or surgical
8 benefits pursuant to the parity requirements of Section 370c.1
9 of the Illinois Insurance Code and the federal Paul Wellstone
10 and Pete Domenici Mental Health Parity and Addiction Equity
11 Act of 2008. Notwithstanding the foregoing, the network
12 adequacy standards for timely and proximate access to
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions shall, at a minimum, satisfy the
15 following requirements:

16 (A) For beneficiaries residing in the metropolitan
17 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
18 network adequacy standards for timely and proximate access
19 to treatment for mental, emotional, nervous, or substance
20 use disorders or conditions means a beneficiary shall not
21 have to travel longer than 30 minutes or 30 miles from the
22 beneficiary's residence to receive outpatient treatment
23 for mental, emotional, nervous, or substance use disorders
24 or conditions. Beneficiaries shall not be required to wait
25 longer than 10 business days between requesting an initial
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (B) For beneficiaries residing in Illinois counties
12 other than those counties listed in subparagraph (A) of
13 this paragraph, network adequacy standards for timely and
14 proximate access to treatment for mental, emotional,
15 nervous, or substance use disorders or conditions means a
16 beneficiary shall not have to travel longer than 60
17 minutes or 60 miles from the beneficiary's residence to
18 receive outpatient treatment for mental, emotional,
19 nervous, or substance use disorders or conditions.
20 Beneficiaries shall not be required to wait longer than 10
21 business days between requesting an initial appointment
22 and being seen by the facility or provider of mental,
23 emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment or to wait longer than
25 20 business days between requesting a repeat or follow-up
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment; however, subject to
3 the protections of paragraph (3) of this subsection, a
4 network plan shall not be held responsible if the
5 beneficiary or provider voluntarily chooses to schedule an
6 appointment outside of these required time frames.

7 (2) For beneficiaries residing in all Illinois counties,
8 network adequacy standards for timely and proximate access to
9 treatment for mental, emotional, nervous, or substance use
10 disorders or conditions means a beneficiary shall not have to
11 travel longer than 60 minutes or 60 miles from the
12 beneficiary's residence to receive inpatient or residential
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions.

15 (3) If there is no in-network facility or provider
16 available for a beneficiary to receive timely and proximate
17 access to treatment for mental, emotional, nervous, or
18 substance use disorders or conditions in accordance with the
19 network adequacy standards outlined in this subsection, the
20 insurer shall provide necessary exceptions to its network to
21 ensure admission and treatment with a provider or at a
22 treatment facility in accordance with the network adequacy
23 standards in this subsection.

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

1 (f) The network plan may consider use of other health care
2 service delivery options, such as telemedicine or telehealth,
3 mobile clinics, and centers of excellence, or other ways of
4 delivering care to partially meet the requirements set under
5 this Section.

6 (g) Except for the requirements set forth in subsection
7 (d-5), insurers who are not able to comply with the provider
8 ratios and time and distance standards established by the
9 Department may request an exception to these requirements from
10 the Department. The Department may grant an exception in the
11 following circumstances:

12 (1) if no providers or facilities meet the specific
13 time and distance standard in a specific service area and
14 the insurer (i) discloses information on the distance and
15 travel time points that beneficiaries would have to travel
16 beyond the required criterion to reach the next closest
17 contracted provider outside of the service area and (ii)
18 provides contact information, including names, addresses,
19 and phone numbers for the next closest contracted provider
20 or facility;

21 (2) if patterns of care in the service area do not
22 support the need for the requested number of provider or
23 facility type and the insurer provides data on local
24 patterns of care, such as claims data, referral patterns,
25 or local provider interviews, indicating where the
26 beneficiaries currently seek this type of care or where

1 the physicians currently refer beneficiaries, or both; or
2 (3) other circumstances deemed appropriate by the
3 Department consistent with the requirements of this Act.

4 (h) Insurers are required to report to the Director any
5 material change to an approved network plan within 15 days
6 after the change occurs and any change that would result in
7 failure to meet the requirements of this Act. Upon notice from
8 the insurer, the Director shall reevaluate the network plan's
9 compliance with the network adequacy and transparency
10 standards of this Act.

11 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
12 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)