

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 Illinois Insurance Code is amended by
5 changing Sections 356z.14, 356z.40, and 370c and by adding
6 Section 355.7 as follows:

7 (215 ILCS 5/355.7 new)

8 Sec. 355.7. Medical loss ratio report and premium rebate.

9 (a) A health insurance issuer offering group or individual
10 health insurance coverage, including a grandfathered health
11 plan, shall, with respect to each plan year, submit to the
12 Director a report concerning the ratio of the incurred loss or
13 incurred claims plus the loss adjustment expense or change in
14 contract reserves to earned premiums. The report shall include
15 the percentage of total premium revenue, after accounting for
16 collections or receipts for risk adjustment and risk corridors
17 and payments of reinsurance, that such coverage expends:

18 (1) on reimbursement for clinical services provided to
19 enrollees under such coverage;

20 (2) for activities that improve health care quality;
21 and

22 (3) on all other non-claims costs, including an
23 explanation of the nature of such costs, and excluding

1 federal and State taxes and licensing or regulatory fees.

2 (b) A health insurance issuer shall comply with subsection
3 (a) by filing with the Director a copy of the report submitted
4 to the United States Department of Health and Human Services
5 under 42 U.S.C. 300gg-18, which must comply with federal
6 regulations promulgated thereunder. The Department shall make
7 the reports received under this Section available to the
8 public on its website.

9 (c) If 42 U.S.C. 300gg-18 or the federal regulations
10 promulgated thereunder are amended after January 15, 2025 to
11 repeal the reporting or rebate requirements, reduce the amount
12 or types of information required to be reported, or adopt a
13 calculation method that reduces the amount of rebates in this
14 State, a health insurance issuer shall file a supplemental
15 report with the Director or make supplemental rebate payments,
16 as applicable, for group or individual health insurance
17 coverage regulated by this State to ensure that the same total
18 information is filed with the Director and the same total
19 rebates are remitted to enrollees as before the federal
20 repeal, reduction, or recalculation took effect.

21 (d) Notwithstanding any other provision of this Section,
22 under no circumstances may the costs described in paragraphs
23 (1) and (2) of subsection (a) include:

24 (1) executive compensation beyond base salary;

25 (2) entity surplus or accumulated profit; or

26 (3) costs attendant with an application for lifestyle

1 management, weight loss, or wellness when the application
2 falls outside the scope of 45 CFR 158.140 through 158.160.

3 (e) This Section does not apply with respect to any policy
4 of excepted benefits as defined under 42 U.S.C. 300gg-91.

5 (f) Notwithstanding anything in this Section to the
6 contrary, this Section does not apply to policies issued or
7 delivered in this State that provide medical assistance under
8 the Illinois Public Aid Code or the Children's Health
9 Insurance Program Act.

10 (215 ILCS 5/356z.14)

11 Sec. 356z.14. Autism spectrum disorders.

12 (a) A group or individual policy of accident and health
13 insurance or managed care plan amended, delivered, issued, or
14 renewed after December 12, 2008 (the effective date of Public
15 Act 95-1005) must provide individuals under 21 years of age
16 coverage for the diagnosis of autism spectrum disorders and
17 for the treatment of autism spectrum disorders to the extent
18 that the diagnosis and treatment of autism spectrum disorders
19 are not already covered by the policy of accident and health
20 insurance or managed care plan.

21 (b) Coverage provided under this Section shall be subject
22 to a maximum benefit of \$36,000 per year, but shall not be
23 subject to any limits on the number of visits to a service
24 provider. ~~The After December 30, 2009, the Director of the~~
25 ~~Division of~~ Insurance shall, on an annual basis, adjust the

1 maximum benefit for inflation using the Medical Care Component
2 of the United States Department of Labor Consumer Price Index
3 for All Urban Consumers. Payments made by an insurer on behalf
4 of a covered individual for any care, treatment, intervention,
5 service, or item, the provision of which was for the treatment
6 of a health condition not diagnosed as an autism spectrum
7 disorder, shall not be applied toward any maximum benefit
8 established under this subsection.

9 (c) Coverage under this Section shall be subject to
10 copayment, deductible, and coinsurance provisions of a policy
11 of accident and health insurance or managed care plan to the
12 extent that other medical services covered by the policy of
13 accident and health insurance or managed care plan are subject
14 to these provisions.

15 (d) This Section shall not be construed as limiting
16 benefits that are otherwise available to an individual under a
17 policy of accident and health insurance or managed care plan
18 and benefits provided under this Section may not be subject to
19 dollar limits, deductibles, copayments, or coinsurance
20 provisions that are less favorable to the insured than the
21 dollar limits, deductibles, or coinsurance provisions that
22 apply to physical illness generally.

23 (e) An insurer may not deny or refuse to provide otherwise
24 covered services, or refuse to renew, refuse to reissue, or
25 otherwise terminate or restrict coverage under an individual
26 contract to provide services to an individual because the

1 individual or the individual's ~~their~~ dependent is diagnosed
2 with an autism spectrum disorder or due to the individual
3 utilizing benefits in this Section.

4 (e-5) An insurer may not deny or refuse to provide
5 otherwise covered services under a group or individual policy
6 of accident and health insurance or a managed care plan solely
7 because of the location wherein the clinically appropriate
8 services are provided.

9 (f) Upon request of the ~~reimbursing~~ insurer, a provider of
10 treatment for autism spectrum disorders shall furnish medical
11 records, clinical notes, or other necessary data that
12 substantiate that initial or continued medical treatment is
13 medically necessary and is resulting in improved clinical
14 status. When treatment is anticipated to require continued
15 services to achieve demonstrable progress, the insurer may
16 request a treatment plan consisting of diagnosis, proposed
17 treatment by type, frequency, anticipated duration of
18 treatment, the anticipated outcomes stated as goals, and the
19 frequency by which the treatment plan will be updated. Nothing
20 in this subsection supersedes the prohibition on prior
21 authorization for mental health treatment under subsection (w)
22 of Section 370c.

23 (g) When making a determination of medical necessity for a
24 treatment modality for autism spectrum disorders, an insurer
25 must make the determination in a manner that is consistent
26 with the manner used to make that determination with respect

1 to other diseases or illnesses covered under the policy,
2 including an appeals process. During the appeals process, any
3 challenge to medical necessity must be viewed as reasonable
4 only if the review includes a physician with expertise in the
5 most current and effective treatment modalities for autism
6 spectrum disorders.

7 (h) Coverage for medically necessary early intervention
8 services must be delivered by certified early intervention
9 specialists, as defined in 89 Ill. Adm. Code 500 and any
10 subsequent amendments thereto.

11 (h-5) If an individual has been diagnosed as having an
12 autism spectrum disorder, meeting the diagnostic criteria in
13 place at the time of diagnosis, and treatment is determined
14 medically necessary, then that individual shall remain
15 eligible for coverage under this Section even if subsequent
16 changes to the diagnostic criteria are adopted by the American
17 Psychiatric Association. If no changes to the diagnostic
18 criteria are adopted after April 1, 2012, and before December
19 31, 2014, then this subsection (h-5) shall be of no further
20 force and effect.

21 (h-10) An insurer may not deny or refuse to provide
22 covered services, or refuse to renew, refuse to reissue, or
23 otherwise terminate or restrict coverage under an individual
24 contract, for a person diagnosed with an autism spectrum
25 disorder on the basis that the individual declined an
26 alternative medication or covered service when the

1 individual's health care provider has determined that such
2 medication or covered service may exacerbate clinical
3 symptomatology and is medically contraindicated for the
4 individual and the individual has requested and received a
5 medical exception as provided for under Section 45.1 of the
6 Managed Care Reform and Patient Rights Act. For the purposes
7 of this subsection (h-10), "clinical symptomatology" means any
8 indication of disorder or disease when experienced by an
9 individual as a change from normal function, sensation, or
10 appearance.

11 (h-15) If, at any time, the Secretary of the United States
12 Department of Health and Human Services, or its successor
13 agency, promulgates rules or regulations to be published in
14 the Federal Register or publishes a comment in the Federal
15 Register or issues an opinion, guidance, or other action that
16 would require the State, pursuant to any provision of the
17 Patient Protection and Affordable Care Act (Public Law
18 111-148), including, but not limited to, 42 U.S.C.
19 18031(d)(3)(B) or any successor provision, to defray the cost
20 of any coverage outlined in subsection (h-10), then subsection
21 (h-10) is inoperative with respect to all coverage outlined in
22 subsection (h-10) other than that authorized under Section
23 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State
24 shall not assume any obligation for the cost of the coverage
25 set forth in subsection (h-10).

26 (i) As used in this Section:

1 "Autism spectrum disorders" means pervasive developmental
2 disorders as defined in the most recent edition of the
3 Diagnostic and Statistical Manual of Mental Disorders,
4 including autism, Asperger's disorder, and pervasive
5 developmental disorder not otherwise specified.

6 "Diagnosis of autism spectrum disorders" means one or more
7 tests, evaluations, or assessments to diagnose whether an
8 individual has autism spectrum disorder that is prescribed,
9 performed, or ordered by (A) a physician licensed to practice
10 medicine in all its branches or (B) a licensed clinical
11 psychologist with expertise in diagnosing autism spectrum
12 disorders.

13 "Medically necessary" means any care, treatment,
14 intervention, service, or item which will or is reasonably
15 expected to do any of the following: (i) prevent the onset of
16 an illness, condition, injury, disease, or disability; (ii)
17 reduce or ameliorate the physical, mental, or developmental
18 effects of an illness, condition, injury, disease, or
19 disability; or (iii) assist to achieve or maintain maximum
20 functional activity in performing daily activities.

21 "Treatment for autism spectrum disorders" shall include
22 the following care prescribed, provided, or ordered for an
23 individual diagnosed with an autism spectrum disorder by (A) a
24 physician licensed to practice medicine in all its branches or
25 (B) a certified, registered, or licensed health care
26 professional with expertise in treating effects of autism

1 spectrum disorders when the care is determined to be medically
2 necessary and ordered by a physician licensed to practice
3 medicine in all its branches:

4 (1) Psychiatric care, meaning direct, consultative, or
5 diagnostic services provided by a licensed psychiatrist.

6 (2) Psychological care, meaning direct or consultative
7 services provided by a licensed psychologist.

8 (3) Habilitative or rehabilitative care, meaning
9 professional, counseling, and guidance services and
10 treatment programs, including applied behavior analysis,
11 that are intended to develop, maintain, and restore the
12 functioning of an individual. As used in this subsection
13 (i), "applied behavior analysis" means the design,
14 implementation, and evaluation of environmental
15 modifications using behavioral stimuli and consequences to
16 produce socially significant improvement in human
17 behavior, including the use of direct observation,
18 measurement, and functional analysis of the relations
19 between environment and behavior.

20 (4) Therapeutic care, including behavioral, speech,
21 occupational, and physical therapies that provide
22 treatment in the following areas: (i) self care and
23 feeding, (ii) pragmatic, receptive, and expressive
24 language, (iii) cognitive functioning, (iv) applied
25 behavior analysis, intervention, and modification, (v)
26 motor planning, and (vi) sensory processing.

1 (j) Rulemaking authority to implement this amendatory Act
2 of the 95th General Assembly, if any, is conditioned on the
3 rules being adopted in accordance with all provisions of the
4 Illinois Administrative Procedure Act and all rules and
5 procedures of the Joint Committee on Administrative Rules; any
6 purported rule not so adopted, for whatever reason, is
7 unauthorized.

8 (Source: P.A. 102-322, eff. 1-1-22; 103-154, eff. 6-30-23;
9 revised 7-23-24.)

10 (215 ILCS 5/356z.40)

11 (Text of Section before amendment by P.A. 103-701 and
12 103-720)

13 Sec. 356z.40. Pregnancy and postpartum coverage.

14 (a) An individual or group policy of accident and health
15 insurance or managed care plan amended, delivered, issued, or
16 renewed on or after October 8, 2021 (the effective date of
17 Public Act 102-665) ~~this amendatory Act of the 102nd General~~
18 ~~Assembly~~ shall provide coverage for pregnancy and newborn care
19 in accordance with 42 U.S.C. 18022(b) regarding essential
20 health benefits.

21 (b) Benefits under this Section shall be as follows:

22 (1) An individual who has been identified as
23 experiencing a high-risk pregnancy by the individual's
24 treating provider shall have access to clinically
25 appropriate case management programs. As used in this

1 subsection, "case management" means a mechanism to
2 coordinate and assure continuity of services, including,
3 but not limited to, health services, social services, and
4 educational services necessary for the individual. "Case
5 management" involves individualized assessment of needs,
6 planning of services, referral, monitoring, and advocacy
7 to assist an individual in gaining access to appropriate
8 services and closure when services are no longer required.
9 "Case management" is an active and collaborative process
10 involving a single qualified case manager, the individual,
11 the individual's family, the providers, and the community.
12 This includes close coordination and involvement with all
13 service providers in the management plan for that
14 individual or family, including assuring that the
15 individual receives the services. As used in this
16 subsection, "high-risk pregnancy" means a pregnancy in
17 which the pregnant or postpartum individual or baby is at
18 an increased risk for poor health or complications during
19 pregnancy or childbirth, including, but not limited to,
20 hypertension disorders, gestational diabetes, and
21 hemorrhage.

22 (2) An individual shall have access to medically
23 necessary treatment of a mental, emotional, nervous, or
24 substance use disorder or condition consistent with the
25 requirements set forth in this Section and in Sections
26 370c and 370c.1 of this Code. Prior authorization

1 requirements are prohibited to the extent provided in
2 Section 370c.

3 (3) The benefits provided for inpatient and outpatient
4 services for the medically necessary treatment of a
5 mental, emotional, nervous, or substance use disorder or
6 condition related to pregnancy or postpartum complications
7 shall be provided ~~if determined to be medically necessary,~~
8 consistent with the requirements of Sections 370c and
9 370c.1 of this Code. The facility or provider shall notify
10 the insurer of both the admission and the initial
11 treatment plan within 48 hours after admission or
12 initiation of treatment. Subject to the requirements of
13 Sections 370c and 370c.1 of this Code, nothing in this
14 paragraph shall prevent an insurer from applying
15 concurrent and post-service utilization review of health
16 care services, including review of medical necessity, case
17 management, experimental and investigational treatments,
18 managed care provisions, and other terms and conditions of
19 the insurance policy.

20 (4) The benefits for the first 48 hours of initiation
21 of services for an inpatient admission, detoxification or
22 withdrawal management program, or partial hospitalization
23 admission for the treatment of a mental, emotional,
24 nervous, or substance use disorder or condition related to
25 pregnancy or postpartum complications shall be provided
26 without post-service or concurrent review of medical

1 necessity, as the medical necessity for the first 48 hours
2 of such services shall be determined solely by the covered
3 pregnant or postpartum individual's provider. Subject to
4 Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in
5 this paragraph shall prevent an insurer from applying
6 concurrent and post-service utilization review, including
7 the review of medical necessity, case management,
8 experimental and investigational treatments, managed care
9 provisions, and other terms and conditions of the
10 insurance policy, of any inpatient admission,
11 detoxification or withdrawal management program admission,
12 or partial hospitalization admission services for the
13 treatment of a mental, emotional, nervous, or substance
14 use disorder or condition related to pregnancy or
15 postpartum complications received 48 hours after the
16 initiation of such services. If an insurer determines that
17 the services are no longer medically necessary, then the
18 covered person shall have the right to external review
19 pursuant to the requirements of the Health Carrier
20 External Review Act.

21 (5) If an insurer determines that continued inpatient
22 care, detoxification or withdrawal management, partial
23 hospitalization, intensive outpatient treatment, or
24 outpatient treatment in a facility is no longer medically
25 necessary, the insurer shall, within 24 hours, provide
26 written notice to the covered pregnant or postpartum

1 individual and the covered pregnant or postpartum
2 individual's provider of its decision and the right to
3 file an expedited internal appeal of the determination.
4 The insurer shall review and make a determination with
5 respect to the internal appeal within 24 hours and
6 communicate such determination to the covered pregnant or
7 postpartum individual and the covered pregnant or
8 postpartum individual's provider. If the determination is
9 to uphold the denial, the covered pregnant or postpartum
10 individual and the covered pregnant or postpartum
11 individual's provider have the right to file an expedited
12 external appeal. An independent review organization shall
13 make a determination within 72 hours. If the insurer's
14 determination is upheld and it is determined that
15 continued inpatient care, detoxification or withdrawal
16 management, partial hospitalization, intensive outpatient
17 treatment, or outpatient treatment is not medically
18 necessary, or if the insurer's determination is not
19 appealed, the insurer shall remain responsible for
20 providing benefits for the inpatient care, detoxification
21 or withdrawal management, partial hospitalization,
22 intensive outpatient treatment, or outpatient treatment
23 through the day following the date the determination is
24 made, and the covered pregnant or postpartum individual
25 shall only be responsible for any applicable copayment,
26 deductible, and coinsurance for the stay through that date

1 as applicable under the policy. The covered pregnant or
2 postpartum individual shall not be discharged or released
3 from the inpatient facility, detoxification or withdrawal
4 management, partial hospitalization, intensive outpatient
5 treatment, or outpatient treatment until all internal
6 appeals and independent utilization review organization
7 appeals are exhausted. A decision to reverse an adverse
8 determination shall comply with the Health Carrier
9 External Review Act.

10 (6) Except as otherwise stated in this subsection (b),
11 the benefits and cost-sharing shall be provided to the
12 same extent as for any other medical condition covered
13 under the policy.

14 (7) The benefits required by paragraphs (2) and (6) of
15 this subsection (b) are to be provided to all covered
16 pregnant or postpartum individuals with a diagnosis of a
17 mental, emotional, nervous, or substance use disorder or
18 condition. The presence of additional related or unrelated
19 diagnoses shall not be a basis to reduce or deny the
20 benefits required by this subsection (b).

21 (Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25;
22 revised 9-10-24.)

23 (Text of Section after amendment by P.A. 103-701 and
24 103-720)

25 Sec. 356z.40. Pregnancy and postpartum coverage.

1 (a) An individual or group policy of accident and health
2 insurance or managed care plan amended, delivered, issued, or
3 renewed on or after October 8, 2021 (the effective date of
4 Public Act 102-665) shall provide coverage for pregnancy and
5 newborn care in accordance with 42 U.S.C. 18022(b) regarding
6 essential health benefits. For policies amended, delivered,
7 issued, or renewed on or after January 1, 2026, this
8 subsection also applies to coverage for postpartum care.

9 (b) Benefits under this Section shall be as follows:

10 (1) An individual who has been identified as
11 experiencing a high-risk pregnancy by the individual's
12 treating provider shall have access to clinically
13 appropriate case management programs. As used in this
14 subsection, "case management" means a mechanism to
15 coordinate and assure continuity of services, including,
16 but not limited to, health services, social services, and
17 educational services necessary for the individual. "Case
18 management" involves individualized assessment of needs,
19 planning of services, referral, monitoring, and advocacy
20 to assist an individual in gaining access to appropriate
21 services and closure when services are no longer required.
22 "Case management" is an active and collaborative process
23 involving a single qualified case manager, the individual,
24 the individual's family, the providers, and the community.
25 This includes close coordination and involvement with all
26 service providers in the management plan for that

1 individual or family, including assuring that the
2 individual receives the services. As used in this
3 subsection, "high-risk pregnancy" means a pregnancy in
4 which the pregnant or postpartum individual or baby is at
5 an increased risk for poor health or complications during
6 pregnancy or childbirth, including, but not limited to,
7 hypertension disorders, gestational diabetes, and
8 hemorrhage.

9 (2) An individual shall have access to medically
10 necessary treatment of a mental, emotional, nervous, or
11 substance use disorder or condition consistent with the
12 requirements set forth in this Section and in Sections
13 370c and 370c.1 of this Code. Prior authorization
14 requirements are prohibited to the extent provided in
15 Section 370c.

16 (3) The benefits provided for inpatient and outpatient
17 services for the medically necessary treatment of a
18 mental, emotional, nervous, or substance use disorder or
19 condition related to pregnancy or postpartum complications
20 shall be provided ~~if determined to be medically necessary,~~
21 consistent with the requirements of Sections 370c and
22 370c.1 of this Code. The facility or provider shall notify
23 the insurer of both the admission and the initial
24 treatment plan within 48 hours after admission or
25 initiation of treatment. Subject to the requirements of
26 Sections 370c and 370c.1 of this Code, nothing in this

1 paragraph shall prevent an insurer from applying
2 concurrent and post-service utilization review of health
3 care services, including review of medical necessity, case
4 management, experimental and investigational treatments,
5 managed care provisions, and other terms and conditions of
6 the insurance policy.

7 (4) The benefits for the first 48 hours of initiation
8 of services for an inpatient admission, detoxification or
9 withdrawal management program, or partial hospitalization
10 admission for the treatment of a mental, emotional,
11 nervous, or substance use disorder or condition related to
12 pregnancy or postpartum complications shall be provided
13 without post-service or concurrent review of medical
14 necessity, as the medical necessity for the first 48 hours
15 of such services shall be determined solely by the covered
16 pregnant or postpartum individual's provider. Subject to
17 Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in
18 this paragraph shall prevent an insurer from applying
19 concurrent and post-service utilization review, including
20 the review of medical necessity, case management,
21 experimental and investigational treatments, managed care
22 provisions, and other terms and conditions of the
23 insurance policy, of any inpatient admission,
24 detoxification or withdrawal management program admission,
25 or partial hospitalization admission services for the
26 treatment of a mental, emotional, nervous, or substance

1 use disorder or condition related to pregnancy or
2 postpartum complications received 48 hours after the
3 initiation of such services. If an insurer determines that
4 the services are no longer medically necessary, then the
5 covered person shall have the right to external review
6 pursuant to the requirements of the Health Carrier
7 External Review Act.

8 (5) If an insurer determines that continued inpatient
9 care, detoxification or withdrawal management, partial
10 hospitalization, intensive outpatient treatment, or
11 outpatient treatment in a facility is no longer medically
12 necessary, the insurer shall, within 24 hours, provide
13 written notice to the covered pregnant or postpartum
14 individual and the covered pregnant or postpartum
15 individual's provider of its decision and the right to
16 file an expedited internal appeal of the determination.
17 The insurer shall review and make a determination with
18 respect to the internal appeal within 24 hours and
19 communicate such determination to the covered pregnant or
20 postpartum individual and the covered pregnant or
21 postpartum individual's provider. If the determination is
22 to uphold the denial, the covered pregnant or postpartum
23 individual and the covered pregnant or postpartum
24 individual's provider have the right to file an expedited
25 external appeal. An independent review organization shall
26 make a determination within 72 hours. If the insurer's

1 determination is upheld and it is determined that
2 continued inpatient care, detoxification or withdrawal
3 management, partial hospitalization, intensive outpatient
4 treatment, or outpatient treatment is not medically
5 necessary, or if the insurer's determination is not
6 appealed, the insurer shall remain responsible for
7 providing benefits for the inpatient care, detoxification
8 or withdrawal management, partial hospitalization,
9 intensive outpatient treatment, or outpatient treatment
10 through the day following the date the determination is
11 made, and the covered pregnant or postpartum individual
12 shall only be responsible for any applicable copayment,
13 deductible, and coinsurance for the stay through that date
14 as applicable under the policy. The covered pregnant or
15 postpartum individual shall not be discharged or released
16 from the inpatient facility, detoxification or withdrawal
17 management, partial hospitalization, intensive outpatient
18 treatment, or outpatient treatment until all internal
19 appeals and independent utilization review organization
20 appeals are exhausted. A decision to reverse an adverse
21 determination shall comply with the Health Carrier
22 External Review Act.

23 (6) Except as otherwise stated in this subsection (b)
24 and subsection (c), the benefits and cost-sharing shall be
25 provided to the same extent as for any other medical
26 condition covered under the policy.

1 (7) The benefits required by paragraphs (2) and (6) of
2 this subsection (b) are to be provided to (i) all covered
3 pregnant or postpartum individuals with a diagnosis of a
4 mental, emotional, nervous, or substance use disorder or
5 condition and (ii) all individuals who have experienced a
6 miscarriage or stillbirth. The presence of additional
7 related or unrelated diagnoses shall not be a basis to
8 reduce or deny the benefits required by this subsection
9 (b).

10 (8) Insurers shall cover all services for pregnancy,
11 postpartum, and newborn care that are rendered by
12 perinatal doulas or licensed certified professional
13 midwives, including home births, home visits, and support
14 during labor, abortion, or miscarriage. Coverage shall
15 include the necessary equipment and medical supplies for a
16 home birth. For home visits by a perinatal doula, not
17 counting any home birth, the policy may limit coverage to
18 16 visits before and 16 visits after a birth, miscarriage,
19 or abortion, provided that the policy shall not be
20 required to cover more than \$8,000 for doula visits for
21 each pregnancy and subsequent postpartum period. As used
22 in this paragraph (8), "perinatal doula" has the meaning
23 given in subsection (a) of Section 5-18.5 of the Illinois
24 Public Aid Code.

25 (9) Coverage for pregnancy, postpartum, and newborn
26 care shall include home visits by lactation consultants

1 and the purchase of breast pumps and breast pump supplies,
2 including such breast pumps, breast pump supplies,
3 breastfeeding supplies, and feeding aids as recommended by
4 the lactation consultant. As used in this paragraph (9),
5 "lactation consultant" means an International
6 Board-Certified Lactation Consultant, a certified
7 lactation specialist with a certification from Lactation
8 Education Consultants, or a certified lactation counselor
9 as defined in subsection (a) of Section 5-18.10 of the
10 Illinois Public Aid Code.

11 (10) Coverage for postpartum services shall apply for
12 all covered services rendered within the first 12 months
13 after the end of pregnancy, subject to any policy
14 limitation on home visits by a perinatal doula allowed
15 under paragraph (8) of this subsection (b). Nothing in
16 this paragraph (10) shall be construed to require a policy
17 to cover services for an individual who is no longer
18 insured or enrolled under the policy. If an individual
19 becomes insured or enrolled under a new policy, the new
20 policy shall cover the individual consistent with the time
21 period and limitations allowed under this paragraph (10).
22 This paragraph (10) is subject to the requirements of
23 Section 25 of the Managed Care Reform and Patient Rights
24 Act, Section 20 of the Network Adequacy and Transparency
25 Act, and 42 U.S.C. 300gg-113.

26 (c) All coverage described in subsection (b), other than

1 health care services for home births, shall be provided
2 without cost-sharing, except that, for mental health services,
3 the cost-sharing prohibition does not apply to inpatient or
4 residential services, and, for substance use disorder
5 services, the cost-sharing prohibition applies only to levels
6 of treatment below and not including Level 3.1 (Clinically
7 Managed Low-Intensity Residential), as established by the
8 American Society for Addiction Medicine. This subsection does
9 not apply to the extent such coverage would disqualify a
10 high-deductible health plan from eligibility for a health
11 savings account pursuant to Section 223 of the Internal
12 Revenue Code.

13 (Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25;
14 103-701, eff. 1-1-26; 103-720, eff. 1-1-26; revised 11-26-24.)

15 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

16 Sec. 370c. Mental and emotional disorders.

17 (a) (1) On and after January 1, 2022 (the effective date of
18 Public Act 102-579), every insurer that amends, delivers,
19 issues, or renews group accident and health policies providing
20 coverage for hospital or medical treatment or services for
21 illness ~~on an expense-incurred basis~~ shall provide coverage
22 for the medically necessary treatment of mental, emotional,
23 nervous, or substance use disorders or conditions consistent
24 with the parity requirements of Section 370c.1 of this Code.

25 (2) Each insured that is covered for mental, emotional,

1 nervous, or substance use disorders or conditions shall be
2 free to select the physician licensed to practice medicine in
3 all its branches, licensed clinical psychologist, licensed
4 clinical social worker, licensed clinical professional
5 counselor, licensed marriage and family therapist, licensed
6 speech-language pathologist, or other licensed or certified
7 professional at a program licensed pursuant to the Substance
8 Use Disorder Act of his or her choice to treat such disorders,
9 and the insurer shall pay the covered charges of such
10 physician licensed to practice medicine in all its branches,
11 licensed clinical psychologist, licensed clinical social
12 worker, licensed clinical professional counselor, licensed
13 marriage and family therapist, licensed speech-language
14 pathologist, or other licensed or certified professional at a
15 program licensed pursuant to the Substance Use Disorder Act up
16 to the limits of coverage, provided (i) the disorder or
17 condition treated is covered by the policy, and (ii) the
18 physician, licensed psychologist, licensed clinical social
19 worker, licensed clinical professional counselor, licensed
20 marriage and family therapist, licensed speech-language
21 pathologist, or other licensed or certified professional at a
22 program licensed pursuant to the Substance Use Disorder Act is
23 authorized to provide said services under the statutes of this
24 State and in accordance with accepted principles of his or her
25 profession.

26 (3) Insofar as this Section applies solely to licensed

1 clinical social workers, licensed clinical professional
2 counselors, licensed marriage and family therapists, licensed
3 speech-language pathologists, and other licensed or certified
4 professionals at programs licensed pursuant to the Substance
5 Use Disorder Act, those persons who may provide services to
6 individuals shall do so after the licensed clinical social
7 worker, licensed clinical professional counselor, licensed
8 marriage and family therapist, licensed speech-language
9 pathologist, or other licensed or certified professional at a
10 program licensed pursuant to the Substance Use Disorder Act
11 has informed the patient of the desirability of the patient
12 conferring with the patient's primary care physician.

13 (4) "Mental, emotional, nervous, or substance use disorder
14 or condition" means a condition or disorder that involves a
15 mental health condition or substance use disorder that falls
16 under any of the diagnostic categories listed in the mental
17 and behavioral disorders chapter of the current edition of the
18 World Health Organization's International Classification of
19 Disease or that is listed in the most recent version of the
20 American Psychiatric Association's Diagnostic and Statistical
21 Manual of Mental Disorders. "Mental, emotional, nervous, or
22 substance use disorder or condition" includes any mental
23 health condition that occurs during pregnancy or during the
24 postpartum period and includes, but is not limited to,
25 postpartum depression.

26 (5) Medically necessary treatment and medical necessity

1 determinations shall be interpreted and made in a manner that
2 is consistent with and pursuant to subsections (h) through (y)
3 ~~(t)~~.

4 (b) (1) (Blank).

5 (2) (Blank).

6 (2.5) (Blank).

7 (3) Unless otherwise prohibited by federal law and
8 consistent with the parity requirements of Section 370c.1 of
9 this Code, the ~~reimbursing~~ insurer that amends, delivers,
10 issues, or renews a group or individual policy of accident and
11 health insurance, a qualified health plan offered through the
12 health insurance marketplace, or a provider of treatment of
13 mental, emotional, nervous, or substance use disorders or
14 conditions shall furnish medical records or other necessary
15 data that substantiate that initial or continued treatment is
16 at all times medically necessary. Nothing in this paragraph
17 (3) supersedes the prohibition on prior authorization
18 requirements to the extent provided under subsections (g) and
19 (w) and subparagraph (A) of paragraph (6.5) of this
20 subsection. An insurer shall provide a mechanism for the
21 timely review by a provider holding the same license and
22 practicing in the same specialty as the patient's provider,
23 who is unaffiliated with the insurer, jointly selected by the
24 patient (or the patient's next of kin or legal representative
25 if the patient is unable to act for himself or herself), the
26 patient's provider, and the insurer in the event of a dispute

1 ~~between the insurer and patient's provider regarding the~~
2 ~~medical necessity of a treatment proposed by a patient's~~
3 ~~provider. If the reviewing provider determines the treatment~~
4 ~~to be medically necessary, the insurer shall provide~~
5 ~~reimbursement for the treatment. Future contractual or~~
6 ~~employment actions by the insurer regarding the patient's~~
7 ~~provider may not be based on the provider's participation in~~
8 ~~this procedure.~~ Nothing prevents the insured from agreeing in
9 writing to continue treatment at his or her expense. When
10 making a determination of the medical necessity for a
11 treatment modality for mental, emotional, nervous, or
12 substance use disorders or conditions, an insurer must make
13 the determination in a manner that is consistent with the
14 manner used to make that determination with respect to other
15 diseases or illnesses covered under the policy, including an
16 appeals process. Medical necessity determinations for
17 substance use disorders shall be made in accordance with
18 appropriate patient placement criteria established by the
19 American Society of Addiction Medicine. No additional criteria
20 may be used to make medical necessity determinations for
21 substance use disorders.

22 (4) A group health benefit plan amended, delivered,
23 issued, or renewed on or after January 1, 2019 (the effective
24 date of Public Act 100-1024) or an individual policy of
25 accident and health insurance or a qualified health plan
26 offered through the health insurance marketplace amended,

1 delivered, issued, or renewed on or after January 1, 2019 (the
2 effective date of Public Act 100-1024):

3 (A) shall provide coverage based upon medical
4 necessity for the treatment of a mental, emotional,
5 nervous, or substance use disorder or condition consistent
6 with the parity requirements of Section 370c.1 of this
7 Code; provided, however, that in each calendar year
8 coverage shall not be less than the following:

9 (i) 45 days of inpatient treatment; and

10 (ii) beginning on June 26, 2006 (the effective
11 date of Public Act 94-921), 60 visits for outpatient
12 treatment including group and individual outpatient
13 treatment; and

14 (iii) for plans or policies delivered, issued for
15 delivery, renewed, or modified after January 1, 2007
16 (the effective date of Public Act 94-906), 20
17 additional outpatient visits for speech therapy for
18 treatment of pervasive developmental disorders that
19 will be in addition to speech therapy provided
20 pursuant to item (ii) of this subparagraph (A); and

21 (B) may not include a lifetime limit on the number of
22 days of inpatient treatment or the number of outpatient
23 visits covered under the plan.

24 (C) (Blank).

25 (5) An issuer of a group health benefit plan or an
26 individual policy of accident and health insurance or a

1 qualified health plan offered through the health insurance
2 marketplace may not count toward the number of outpatient
3 visits required to be covered under this Section an outpatient
4 visit for the purpose of medication management and shall cover
5 the outpatient visits under the same terms and conditions as
6 it covers outpatient visits for the treatment of physical
7 illness.

8 (5.5) An individual or group health benefit plan amended,
9 delivered, issued, or renewed on or after September 9, 2015
10 (the effective date of Public Act 99-480) shall offer coverage
11 for medically necessary acute treatment services and medically
12 necessary clinical stabilization services. The treating
13 provider shall base all treatment recommendations and the
14 health benefit plan shall base all medical necessity
15 determinations for substance use disorders in accordance with
16 the most current edition of the Treatment Criteria for
17 Addictive, Substance-Related, and Co-Occurring Conditions
18 established by the American Society of Addiction Medicine. The
19 treating provider shall base all treatment recommendations and
20 the health benefit plan shall base all medical necessity
21 determinations for medication-assisted treatment in accordance
22 with the most current Treatment Criteria for Addictive,
23 Substance-Related, and Co-Occurring Conditions established by
24 the American Society of Addiction Medicine.

25 As used in this subsection:

26 "Acute treatment services" means 24-hour medically

1 supervised addiction treatment that provides evaluation and
2 withdrawal management and may include biopsychosocial
3 assessment, individual and group counseling, psychoeducational
4 groups, and discharge planning.

5 "Clinical stabilization services" means 24-hour treatment,
6 usually following acute treatment services for substance
7 abuse, which may include intensive education and counseling
8 regarding the nature of addiction and its consequences,
9 relapse prevention, outreach to families and significant
10 others, and aftercare planning for individuals beginning to
11 engage in recovery from addiction.

12 "Prior authorization" has the meaning given to that term
13 in Section 15 of the Prior Authorization Reform Act.

14 (6) An issuer of a group health benefit plan may provide or
15 offer coverage required under this Section through a managed
16 care plan.

17 (6.5) An individual or group health benefit plan amended,
18 delivered, issued, or renewed on or after January 1, 2019 (the
19 effective date of Public Act 100-1024):

20 (A) shall not impose prior authorization requirements,
21 including limitations on dosage, other than those
22 established under the Treatment Criteria for Addictive,
23 Substance-Related, and Co-Occurring Conditions
24 established by the American Society of Addiction Medicine,
25 on a prescription medication approved by the United States
26 Food and Drug Administration that is prescribed or

1 administered for the treatment of substance use disorders;

2 (B) shall not impose any step therapy requirements;

3 (C) shall place all prescription medications approved
4 by the United States Food and Drug Administration
5 prescribed or administered for the treatment of substance
6 use disorders on, for brand medications, the lowest tier
7 of the drug formulary developed and maintained by the
8 individual or group health benefit plan that covers brand
9 medications and, for generic medications, the lowest tier
10 of the drug formulary developed and maintained by the
11 individual or group health benefit plan that covers
12 generic medications; and

13 (D) shall not exclude coverage for a prescription
14 medication approved by the United States Food and Drug
15 Administration for the treatment of substance use
16 disorders and any associated counseling or wraparound
17 services on the grounds that such medications and services
18 were court ordered.

19 (7) (Blank).

20 (8) (Blank).

21 (9) With respect to all mental, emotional, nervous, or
22 substance use disorders or conditions, coverage for inpatient
23 treatment shall include coverage for treatment in a
24 residential treatment center certified or licensed by the
25 Department of Public Health or the Department of Human
26 Services.

1 (c) This Section shall not be interpreted to require
2 coverage for speech therapy or other habilitative services for
3 those individuals covered under Section 356z.15 of this Code.

4 (d) With respect to a group or individual policy of
5 accident and health insurance or a qualified health plan
6 offered through the health insurance marketplace, the
7 Department and, with respect to medical assistance, the
8 Department of Healthcare and Family Services shall each
9 enforce the requirements of this Section and Sections 356z.23
10 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
11 Mental Health Parity and Addiction Equity Act of 2008, 42
12 U.S.C. 18031(j), and any amendments to, and federal guidance
13 or regulations issued under, those Acts, including, but not
14 limited to, final regulations issued under the Paul Wellstone
15 and Pete Domenici Mental Health Parity and Addiction Equity
16 Act of 2008 and final regulations applying the Paul Wellstone
17 and Pete Domenici Mental Health Parity and Addiction Equity
18 Act of 2008 to Medicaid managed care organizations, the
19 Children's Health Insurance Program, and alternative benefit
20 plans. Specifically, the Department and the Department of
21 Healthcare and Family Services shall take action:

22 (1) proactively ensuring compliance by individual and
23 group policies, including by requiring that insurers
24 submit comparative analyses, as set forth in paragraph (6)
25 of subsection (k) of Section 370c.1, demonstrating how
26 they design and apply nonquantitative treatment

1 limitations, both as written and in operation, for mental,
2 emotional, nervous, or substance use disorder or condition
3 benefits as compared to how they design and apply
4 nonquantitative treatment limitations, as written and in
5 operation, for medical and surgical benefits;

6 (2) evaluating all consumer or provider complaints
7 regarding mental, emotional, nervous, or substance use
8 disorder or condition coverage for possible parity
9 violations;

10 (3) performing parity compliance market conduct
11 examinations or, in the case of the Department of
12 Healthcare and Family Services, parity compliance audits
13 of individual and group plans and policies, including, but
14 not limited to, reviews of:

15 (A) nonquantitative treatment limitations,
16 including, but not limited to, prior authorization
17 requirements, concurrent review, retrospective review,
18 step therapy, network admission standards,
19 reimbursement rates, and geographic restrictions;

20 (B) denials of authorization, payment, and
21 coverage; and

22 (C) other specific criteria as may be determined
23 by the Department.

24 The findings and the conclusions of the parity compliance
25 market conduct examinations and audits shall be made public.

26 The Director may adopt rules to effectuate any provisions

1 of the Paul Wellstone and Pete Domenici Mental Health Parity
2 and Addiction Equity Act of 2008 that relate to the business of
3 insurance.

4 (e) Availability of plan information.

5 (1) The criteria for medical necessity determinations
6 made under a group health plan, an individual policy of
7 accident and health insurance, or a qualified health plan
8 offered through the health insurance marketplace with
9 respect to mental health or substance use disorder
10 benefits (or health insurance coverage offered in
11 connection with the plan with respect to such benefits)
12 must be made available by the plan administrator (or the
13 health insurance issuer offering such coverage) to any
14 current or potential participant, beneficiary, or
15 contracting provider upon request.

16 (2) The reason for any denial under a group health
17 benefit plan, an individual policy of accident and health
18 insurance, or a qualified health plan offered through the
19 health insurance marketplace (or health insurance coverage
20 offered in connection with such plan or policy) of
21 reimbursement or payment for services with respect to
22 mental, emotional, nervous, or substance use disorders or
23 conditions benefits in the case of any participant or
24 beneficiary must be made available within a reasonable
25 time and in a reasonable manner and in readily
26 understandable language by the plan administrator (or the

1 health insurance issuer offering such coverage) to the
2 participant or beneficiary upon request.

3 (f) As used in this Section, "group policy of accident and
4 health insurance" and "group health benefit plan" includes (1)
5 State-regulated employer-sponsored group health insurance
6 plans written in Illinois or which purport to provide coverage
7 for a resident of this State; and (2) State, county,
8 municipal, or school district employee health plans.
9 References to an insurer include all plans described in this
10 subsection.

11 (g) (1) As used in this subsection:

12 "Benefits", with respect to insurers that are not Medicaid
13 managed care organizations, means the benefits provided for
14 treatment services for inpatient and outpatient treatment of
15 substance use disorders or conditions at American Society of
16 Addiction Medicine levels of treatment 2.1 (Intensive
17 Outpatient), 2.5 (High-Intensity Outpatient) ~~(Partial~~
18 ~~Hospitalization)~~, 3.1 (Clinically Managed Low-Intensity
19 Residential), ~~3.3 (Clinically Managed Population Specific~~
20 ~~High-Intensity Residential)~~, 3.5 (Clinically Managed
21 High-Intensity Residential), and 3.7 (Medically Managed
22 Residential ~~Monitored Intensive Inpatient~~) and OMT (Opioid
23 Maintenance Therapy) services.

24 "Benefits", with respect to Medicaid managed care
25 organizations, means the benefits provided for treatment
26 services for inpatient and outpatient treatment of substance

1 use disorders or conditions at American Society of Addiction
2 Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5
3 (High-Intensity Outpatient) ~~(Partial Hospitalization)~~, 3.5
4 (Clinically Managed High-Intensity Residential), and 3.7
5 (Medically Managed Residential ~~Monitored Intensive Inpatient~~)
6 and OMT (Opioid Maintenance Therapy) services.

7 "Substance use disorder treatment provider or facility"
8 means a licensed physician, licensed psychologist, licensed
9 psychiatrist, licensed advanced practice registered nurse, or
10 licensed, certified, or otherwise State-approved facility or
11 provider of substance use disorder treatment.

12 (2) A group health insurance policy, an individual health
13 benefit plan, or qualified health plan that is offered through
14 the health insurance marketplace, small employer group health
15 plan, and large employer group health plan that is amended,
16 delivered, issued, executed, or renewed in this State, or
17 approved for issuance or renewal in this State, on or after
18 January 1, 2019 (the effective date of Public Act 100-1023)
19 shall comply with the requirements of this Section and Section
20 370c.1. The services for the treatment and the ongoing
21 assessment of the patient's progress in treatment shall follow
22 the requirements of 77 Ill. Adm. Code 2060.

23 (3) Prior authorization shall not be utilized for the
24 benefits under this subsection. Except to the extent
25 prohibited by Section 370c.1 with respect to treatment
26 limitations in a benefit classification or subclassification,

1 the insurer may require the ~~The~~ substance use disorder
2 treatment provider or facility to ~~shall~~ notify the insurer of
3 the initiation of treatment. For an insurer that is not a
4 Medicaid managed care organization, the substance use disorder
5 treatment provider or facility may be required to give
6 notification ~~shall occur~~ for the initiation of treatment of
7 the covered person within 2 business days. For Medicaid
8 managed care organizations, the substance use disorder
9 treatment provider or facility may be required to give
10 notification ~~shall occur~~ in accordance with the protocol set
11 forth in the provider agreement for initiation of treatment
12 within 24 hours. If the Medicaid managed care organization is
13 not capable of accepting the notification in accordance with
14 the contractual protocol during the 24-hour period following
15 admission, the substance use disorder treatment provider or
16 facility shall have one additional business day to provide the
17 notification to the appropriate managed care organization.
18 Treatment plans shall be developed in accordance with the
19 requirements and timeframes established in 77 Ill. Adm. Code
20 2060. No such coverage shall be subject to concurrent review
21 prior to the applicable notification deadline. If coverage is
22 denied retrospectively, neither the provider or facility nor
23 the insurer shall bill, and the covered individual shall not
24 be liable, for any treatment under this subsection through the
25 date the adverse determination is issued, other than any
26 copayment, coinsurance, or deductible for the treatment or

1 stay through that date as applicable under the policy.
2 Coverage shall not be retrospectively denied for benefits that
3 were furnished at a participating substance use disorder
4 facility prior to the applicable notification deadline except
5 for the following: ~~If the substance use disorder treatment~~
6 ~~provider or facility fails to notify the insurer of the~~
7 ~~initiation of treatment in accordance with these provisions,~~
8 ~~the insurer may follow its normal prior authorization~~
9 ~~processes.~~

10 (A) upon reasonable determination that the benefits
11 were not provided;

12 (B) upon determination that the patient receiving the
13 treatment was not an insured, enrollee, or beneficiary
14 under the policy;

15 (C) upon material misrepresentation by the patient or
16 provider. As used in this subparagraph (C), "material"
17 means a fact or situation that is not merely technical in
18 nature and results or could result in a substantial change
19 in the situation;

20 (D) upon determination that a service was excluded
21 under the terms of coverage. For situations that qualify
22 under this subparagraph (D), the limitation to billing for
23 a copayment, coinsurance, or deductible shall not apply;

24 (E) upon determination that a service was not
25 medically necessary consistent with subsections (h)
26 through (n); or

1 (F) upon determination that the patient did not
2 consent to the treatment and that there was no court order
3 mandating the treatment.

4 (4) For an insurer that is not a Medicaid managed care
5 organization, if an insurer determines that benefits are no
6 longer medically necessary, the insurer shall notify the
7 covered person, the covered person's authorized
8 representative, if any, and the covered person's health care
9 provider in writing of the covered person's right to request
10 an external review pursuant to the Health Carrier External
11 Review Act. The notification shall occur within 24 hours
12 following the adverse determination.

13 Pursuant to the requirements of the Health Carrier
14 External Review Act, the covered person or the covered
15 person's authorized representative may request an expedited
16 external review. An expedited external review may not occur if
17 the substance use disorder treatment provider or facility
18 determines that continued treatment is no longer medically
19 necessary.

20 If an expedited external review request meets the criteria
21 of the Health Carrier External Review Act, an independent
22 review organization shall make a final determination of
23 medical necessity within 72 hours. If an independent review
24 organization upholds an adverse determination, an insurer
25 shall remain responsible to provide coverage of benefits
26 through the day following the determination of the independent

1 review organization. A decision to reverse an adverse
2 determination shall comply with the Health Carrier External
3 Review Act.

4 (5) The substance use disorder treatment provider or
5 facility shall provide the insurer with 7 business days'
6 advance notice of the planned discharge of the patient from
7 the substance use disorder treatment provider or facility and
8 notice on the day that the patient is discharged from the
9 substance use disorder treatment provider or facility.

10 (6) The benefits required by this subsection shall be
11 provided to all covered persons with a diagnosis of substance
12 use disorder or conditions. The presence of additional related
13 or unrelated diagnoses shall not be a basis to reduce or deny
14 the benefits required by this subsection.

15 (7) Nothing in this subsection shall be construed to
16 require an insurer to provide coverage for any of the benefits
17 in this subsection.

18 (8) Any concurrent or retrospective review permitted by
19 this subsection must be consistent with the utilization review
20 provisions in subsections (h) through (n).

21 (h) As used in this Section:

22 "Generally accepted standards of mental, emotional,
23 nervous, or substance use disorder or condition care" means
24 standards of care and clinical practice that are generally
25 recognized by health care providers practicing in relevant
26 clinical specialties such as psychiatry, psychology, clinical

1 sociology, social work, addiction medicine and counseling, and
2 behavioral health treatment. Valid, evidence-based sources
3 reflecting generally accepted standards of mental, emotional,
4 nervous, or substance use disorder or condition care include
5 peer-reviewed scientific studies and medical literature,
6 recommendations of nonprofit health care provider professional
7 associations and specialty societies, including, but not
8 limited to, patient placement criteria and clinical practice
9 guidelines, recommendations of federal government agencies,
10 and drug labeling approved by the United States Food and Drug
11 Administration.

12 "Medically necessary treatment of mental, emotional,
13 nervous, or substance use disorders or conditions" means a
14 service or product addressing the specific needs of that
15 patient, for the purpose of screening, preventing, diagnosing,
16 managing, or treating an illness, injury, or condition or its
17 symptoms and comorbidities, including minimizing the
18 progression of an illness, injury, or condition or its
19 symptoms and comorbidities in a manner that is all of the
20 following:

21 (1) in accordance with the generally accepted
22 standards of mental, emotional, nervous, or substance use
23 disorder or condition care;

24 (2) clinically appropriate in terms of type,
25 frequency, extent, site, and duration; and

26 (3) not primarily for the economic benefit of the

1 insurer, purchaser, or for the convenience of the patient,
2 treating physician, or other health care provider.

3 "Utilization review" means either of the following:

4 (1) prospectively, retrospectively, or concurrently
5 reviewing and approving, modifying, delaying, or denying,
6 based in whole or in part on medical necessity, requests
7 by health care providers, insureds, or their authorized
8 representatives for coverage of health care services
9 before, retrospectively, or concurrently with the
10 provision of health care services to insureds.

11 (2) evaluating the medical necessity, appropriateness,
12 level of care, service intensity, efficacy, or efficiency
13 of health care services, benefits, procedures, or
14 settings, under any circumstances, to determine whether a
15 health care service or benefit subject to a medical
16 necessity coverage requirement in an insurance policy is
17 covered as medically necessary for an insured.

18 "Utilization review criteria" means patient placement
19 criteria or any criteria, standards, protocols, or guidelines
20 used by an insurer to conduct utilization review.

21 (i)(1) Every insurer that amends, delivers, issues, or
22 renews a group or individual policy of accident and health
23 insurance or a qualified health plan offered through the
24 health insurance marketplace in this State and Medicaid
25 managed care organizations providing coverage for hospital or
26 medical treatment on or after January 1, 2023 shall, pursuant

1 to subsections (h) through (s), provide coverage for medically
2 necessary treatment of mental, emotional, nervous, or
3 substance use disorders or conditions.

4 (2) An insurer shall not set a specific limit on the
5 duration of benefits or coverage of medically necessary
6 treatment of mental, emotional, nervous, or substance use
7 disorders or conditions or limit coverage only to alleviation
8 of the insured's current symptoms.

9 (3) All utilization review conducted by the insurer
10 concerning diagnosis, prevention, and treatment of insureds
11 diagnosed with mental, emotional, nervous, or substance use
12 disorders or conditions shall be conducted in accordance with
13 the requirements of subsections (k) through (w).

14 (4) An insurer that authorizes a specific type of
15 treatment by a provider pursuant to this Section shall not
16 rescind or modify the authorization after that provider
17 renders the health care service in good faith and pursuant to
18 this authorization for any reason, including, but not limited
19 to, the insurer's subsequent cancellation or modification of
20 the insured's or policyholder's contract, or the insured's or
21 policyholder's eligibility. Nothing in this Section shall
22 require the insurer to cover a treatment when the
23 authorization was granted based on a material
24 misrepresentation by the insured, the policyholder, or the
25 provider. Nothing in this Section shall require Medicaid
26 managed care organizations to pay for services if the

1 individual was not eligible for Medicaid at the time the
2 service was rendered. Nothing in this Section shall require an
3 insurer to pay for services if the individual was not the
4 insurer's enrollee at the time services were rendered. As used
5 in this paragraph, "material" means a fact or situation that
6 is not merely technical in nature and results in or could
7 result in a substantial change in the situation.

8 (j) An insurer shall not limit benefits or coverage for
9 medically necessary services on the basis that those services
10 should be or could be covered by a public entitlement program,
11 including, but not limited to, special education or an
12 individualized education program, Medicaid, Medicare,
13 Supplemental Security Income, or Social Security Disability
14 Insurance, and shall not include or enforce a contract term
15 that excludes otherwise covered benefits on the basis that
16 those services should be or could be covered by a public
17 entitlement program. Nothing in this subsection shall be
18 construed to require an insurer to cover benefits that have
19 been authorized and provided for a covered person by a public
20 entitlement program. Medicaid managed care organizations are
21 not subject to this subsection.

22 (k) An insurer shall base any medical necessity
23 determination or the utilization review criteria that the
24 insurer, and any entity acting on the insurer's behalf,
25 applies to determine the medical necessity of health care
26 services and benefits for the diagnosis, prevention, and

1 treatment of mental, emotional, nervous, or substance use
2 disorders or conditions on current generally accepted
3 standards of mental, emotional, nervous, or substance use
4 disorder or condition care. All denials and appeals shall be
5 reviewed by a professional with experience or expertise
6 comparable to the provider requesting the authorization.

7 (l) In conducting utilization review of all covered health
8 care services for the diagnosis, prevention, and treatment of
9 mental, emotional, and nervous disorders or conditions, an
10 insurer shall apply the criteria and guidelines set forth in
11 the most recent version of the treatment criteria developed by
12 an unaffiliated nonprofit professional association for the
13 relevant clinical specialty or, for Medicaid managed care
14 organizations, criteria and guidelines determined by the
15 Department of Healthcare and Family Services that are
16 consistent with generally accepted standards of mental,
17 emotional, nervous or substance use disorder or condition
18 care. Pursuant to subsection (b), in conducting utilization
19 review of all covered services and benefits for the diagnosis,
20 prevention, and treatment of substance use disorders an
21 insurer shall use the most recent edition of the patient
22 placement criteria established by the American Society of
23 Addiction Medicine.

24 (m) In conducting utilization review relating to level of
25 care placement, continued stay, transfer, discharge, or any
26 other patient care decisions that are within the scope of the

1 sources specified in subsection (l), an insurer shall not
2 apply different, additional, conflicting, or more restrictive
3 utilization review criteria than the criteria set forth in
4 those sources. For all level of care placement decisions, the
5 insurer shall authorize placement at the level of care
6 consistent with the assessment of the insured using the
7 relevant patient placement criteria as specified in subsection
8 (l). If that level of placement is not available, the insurer
9 shall authorize the next higher level of care. In the event of
10 disagreement, the insurer shall provide full detail of its
11 assessment using the relevant criteria as specified in
12 subsection (l) to the provider of the service and the patient.

13 If an insurer purchases or licenses utilization review
14 criteria pursuant to this subsection, the insurer shall verify
15 and document before use that the criteria were developed in
16 accordance with subsection (k).

17 (n) In conducting utilization review that is outside the
18 scope of the criteria as specified in subsection (l) or
19 relates to the advancements in technology or in the types or
20 levels of care that are not addressed in the most recent
21 versions of the sources specified in subsection (l), an
22 insurer shall conduct utilization review in accordance with
23 subsection (k).

24 (o) This Section does not in any way limit the rights of a
25 patient under the Medical Patient Rights Act.

26 (p) This Section does not in any way limit early and

1 periodic screening, diagnostic, and treatment benefits as
2 defined under 42 U.S.C. 1396d(r).

3 (q) To ensure the proper use of the criteria described in
4 subsection (l), every insurer shall do all of the following:

5 (1) Educate the insurer's staff, including any third
6 parties contracted with the insurer to review claims,
7 conduct utilization reviews, or make medical necessity
8 determinations about the utilization review criteria.

9 (2) Make the educational program available to other
10 stakeholders, including the insurer's participating or
11 contracted providers and potential participants,
12 beneficiaries, or covered lives. The education program
13 must be provided at least once a year, in-person or
14 digitally, or recordings of the education program must be
15 made available to the aforementioned stakeholders.

16 (3) Provide, at no cost, the utilization review
17 criteria and any training material or resources to
18 providers and insured patients upon request. For
19 utilization review criteria not concerning level of care
20 placement, continued stay, transfer, discharge, or other
21 patient care decisions used by the insurer pursuant to
22 subsection (m), the insurer may place the criteria on a
23 secure, password-protected website so long as the access
24 requirements of the website do not unreasonably restrict
25 access to insureds or their providers. No restrictions
26 shall be placed upon the insured's or treating provider's

1 access right to utilization review criteria obtained under
2 this paragraph at any point in time, including before an
3 initial request for authorization.

4 (4) Track, identify, and analyze how the utilization
5 review criteria are used to certify care, deny care, and
6 support the appeals process.

7 (5) Conduct interrater reliability testing to ensure
8 consistency in utilization review decision making that
9 covers how medical necessity decisions are made; this
10 assessment shall cover all aspects of utilization review
11 as defined in subsection (h).

12 (6) Run interrater reliability reports about how the
13 clinical guidelines are used in conjunction with the
14 utilization review process and parity compliance
15 activities.

16 (7) Achieve interrater reliability pass rates of at
17 least 90% and, if this threshold is not met, immediately
18 provide for the remediation of poor interrater reliability
19 and interrater reliability testing for all new staff
20 before they can conduct utilization review without
21 supervision.

22 (8) Maintain documentation of interrater reliability
23 testing and the remediation actions taken for those with
24 pass rates lower than 90% and submit to the Department of
25 Insurance or, in the case of Medicaid managed care
26 organizations, the Department of Healthcare and Family

1 Services the testing results and a summary of remedial
2 actions as part of parity compliance reporting set forth
3 in subsection (k) of Section 370c.1.

4 (r) This Section applies to all health care services and
5 benefits for the diagnosis, prevention, and treatment of
6 mental, emotional, nervous, or substance use disorders or
7 conditions covered by an insurance policy, including
8 prescription drugs.

9 (s) This Section applies to an insurer that amends,
10 delivers, issues, or renews a group or individual policy of
11 accident and health insurance or a qualified health plan
12 offered through the health insurance marketplace in this State
13 providing coverage for hospital or medical treatment and
14 conducts utilization review as defined in this Section,
15 including Medicaid managed care organizations, and any entity
16 or contracting provider that performs utilization review or
17 utilization management functions on an insurer's behalf.

18 (t) If the Director determines that an insurer has
19 violated this Section, the Director may, after appropriate
20 notice and opportunity for hearing, by order, assess a civil
21 penalty between \$1,000 and \$5,000 for each violation. Moneys
22 collected from penalties shall be deposited into the Parity
23 Advancement Fund established in subsection (i) of Section
24 370c.1.

25 (u) An insurer shall not adopt, impose, or enforce terms
26 in its policies or provider agreements, in writing or in

1 operation, that undermine, alter, or conflict with the
2 requirements of this Section.

3 (v) The provisions of this Section are severable. If any
4 provision of this Section or its application is held invalid,
5 that invalidity shall not affect other provisions or
6 applications that can be given effect without the invalid
7 provision or application.

8 (w) Beginning January 1, 2026, coverage for medically
9 necessary treatment of mental, emotional, or nervous disorders
10 or conditions ~~for inpatient mental health treatment at~~
11 ~~participating hospitals~~ shall comply with the following
12 requirements:

13 (1) ~~No Subject to paragraphs (2) and (3) of this~~
14 ~~subsection, no~~ policy shall require prior authorization
15 for outpatient or partial hospitalization services for
16 treatment of mental, emotional, or nervous disorders or
17 conditions provided by a physician licensed to practice
18 medicine in all branches, a licensed clinical
19 psychologist, a licensed clinical social worker, a
20 licensed clinical professional counselor, a licensed
21 marriage and family therapist, a licensed speech-language
22 pathologist, or any other type of licensed, certified, or
23 legally authorized provider, including trainees working
24 under the supervision of a licensed health care
25 professional listed under this subsection, or facility
26 whose outpatient or partial hospitalization services the

1 policy covers for treatment of mental, emotional, or
2 nervous disorders or conditions. Such coverage may be
3 subject to concurrent and retrospective review consistent
4 with the utilization review provisions in subsections (h)
5 through (n) and Section 370c.1. Nothing in this paragraph
6 (1) supersedes a health maintenance organization's
7 referral requirement for services from nonparticipating
8 providers. An insurer may require providers or facilities
9 to notify the insurer of the initiation of treatment as
10 specified in this subsection, except to the extent
11 prohibited by Section 370c.1 with respect to treatment
12 limitations in a benefit classification or
13 subclassification. No such coverage shall be subject to
14 concurrent review for any services furnished before an
15 applicable notification deadline, subject to the
16 following: admission for such treatment at any
17 participating hospital.

18 (A) In the case of outpatient treatment, for an
19 insurer that is not a Medicaid managed care
20 organization, the insurer may set a notification
21 deadline of 2 business days after the initiation of
22 the covered person's treatment. A Medicaid managed
23 care organization may set a deadline of 24 hours after
24 the initiation of treatment. If the Medicaid managed
25 care organization is not capable of accepting the
26 notification in accordance with the contractual

1 protocol within the 24-hour period following
2 initiation, the treatment provider or facility shall
3 have one additional business day to provide the
4 notification to the Medicaid managed care
5 organization.

6 (B) In the case of a partial hospitalization
7 program, for an insurer that is not a Medicaid managed
8 care organization, the insurer may set a notification
9 deadline of 48 hours after the initiation of the
10 covered person's treatment. A Medicaid managed care
11 organization may set a deadline of 24 hours after the
12 initiation of treatment. If the Medicaid managed care
13 organization is not capable of accepting the
14 notification in accordance with the contractual
15 protocol during the 24-hour period following
16 initiation, the treatment provider or facility shall
17 have one additional business day to provide the
18 notification to the Medicaid managed care
19 organization.

20 (2) No policy shall require prior authorization for
21 inpatient treatment at a hospital for mental, emotional,
22 or nervous disorders or conditions at a participating
23 provider. Additionally, no such coverage shall ~~Coverage~~
24 ~~provided under this subsection also shall not~~ be subject
25 to concurrent review for the first 72 hours after
26 admission, provided that the provider ~~hospital~~ must notify

1 the insurer of both the admission and the initial
2 treatment plan within 48 hours of admission. A discharge
3 plan must be fully developed and continuity services
4 prepared to meet the patient's needs and the patient's
5 community preference upon release. ~~Nothing in this~~
6 ~~paragraph supersedes a health maintenance organization's~~
7 ~~referral requirement for services from nonparticipating~~
8 ~~providers upon a patient's discharge from a hospital~~
9 Recommended level of care placements identified in the
10 discharge plan shall comply with generally accepted
11 standards of care, as defined in subsection (h).

12 (A) If the provider satisfies the conditions of
13 paragraph (2), then the insurer shall approve coverage
14 of the recommended level of care, if applicable, upon
15 discharge subject to concurrent review.

16 (B) Nothing in this paragraph supersedes a health
17 maintenance organization's referral requirement for
18 services from nonparticipating providers upon a
19 patient's discharge from a hospital or facility.

20 (C) Concurrent review for such coverage must be
21 consistent with the utilization review provisions in
22 subsections (h) through (n).

23 (D) In this subsection, residential treatment that
24 is not otherwise identified in the discharge plan is
25 not inpatient hospitalization.

26 (3) Treatment provided under this subsection may be

1 reviewed retrospectively. If coverage is denied
2 retrospectively, neither the insurer nor the participating
3 provider ~~hospital~~ shall bill, and the insured shall not be
4 liable, for any treatment under this subsection through
5 the date the adverse determination is issued, other than
6 any copayment, coinsurance, or deductible for the stay
7 through that date as applicable under the policy. Coverage
8 shall not be retrospectively denied for the first 72 hours
9 of admission to inpatient hospitalization for treatment of
10 mental, emotional, or nervous disorders or conditions, or
11 before the applicable deadline under paragraph (1) of this
12 subsection for outpatient treatment or partial
13 hospitalization programs, ~~treatment~~ at a participating
14 provider ~~hospital~~ except:

15 (A) upon reasonable determination that the
16 inpatient mental health treatment was not provided;

17 (B) upon determination that the patient receiving
18 the treatment was not an insured, enrollee, or
19 beneficiary under the policy;

20 (C) upon material misrepresentation by the patient
21 or health care provider. In this item (C), "material"
22 means a fact or situation that is not merely technical
23 in nature and results or could result in a substantial
24 change in the situation; ~~or~~

25 (D) upon determination that a service was excluded
26 under the terms of coverage. In that case, the

1 limitation to billing for a copayment, coinsurance, or
2 deductible shall not apply;

3 (E) for outpatient treatment or partial
4 hospitalization programs only, upon determination that
5 a service was not medically necessary consistent with
6 subsections (h) through (n); or

7 (F) upon determination that the patient did not
8 consent to the treatment and that there was no court
9 order mandating the treatment.

10 ~~(4)~~ Nothing in this subsection shall be construed to
11 require a policy to cover any health care service excluded
12 under the terms of coverage.

13 This subsection does not apply to coverage for any
14 prescription or over-the-counter drug.

15 Nothing in this subsection shall be construed to
16 require the medical assistance program to reimburse for
17 services not covered by the medical assistance program as
18 authorized by the Illinois Public Aid Code or the
19 Children's Health Insurance Program Act.

20 (x) Notwithstanding any provision of this Section, nothing
21 shall require the medical assistance program under Article V
22 of the Illinois Public Aid Code or the Children's Health
23 Insurance Program Act to violate any applicable federal laws,
24 regulations, or grant requirements, including requirements for
25 utilization management, or any State or federal consent
26 decrees. Nothing in subsection (g) or ~~subsection (w)~~ shall

1 prevent the Department of Healthcare and Family Services from
2 requiring a health care provider to use specified level of
3 care, admission, continued stay, or discharge criteria,
4 including, but not limited to, those under Section 5-5.23 of
5 the Illinois Public Aid Code, as long as the Department of
6 Healthcare and Family Services, subject to applicable federal
7 laws, regulations, or grant requirements, including
8 requirements for utilization management, does not require a
9 health care provider to seek prior authorization or concurrent
10 review from the Department of Healthcare and Family Services,
11 a Medicaid managed care organization, or a utilization review
12 organization under the circumstances expressly prohibited by
13 subsections (g) and ~~subsection~~ (w). Nothing in this Section
14 prohibits a health plan, including a Medicaid managed care
15 organization, from conducting reviews for medical necessity,
16 clinical appropriateness, safety, fraud, waste, or abuse and
17 reporting suspected fraud, waste, or abuse according to State
18 and federal requirements. Nothing in this Section limits the
19 authority of the Department of Healthcare and Family Services
20 or another State agency, or a Medicaid managed care
21 organization on the State agency's behalf, to (i) implement or
22 require programs, services, screenings, assessments, tools, or
23 reviews to comply with applicable federal law, federal
24 regulation, federal grant requirements, any State or federal
25 consent decrees or court orders, or any applicable case law,
26 such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii)

1 administer or require programs, services, screenings,
2 assessments, tools, or reviews established under State or
3 federal laws, rules, or regulations in compliance with State
4 or federal laws, rules, or regulations, including, but not
5 limited to, the Children's Mental Health Act and the Mental
6 Health and Developmental Disabilities Administrative Act.

7 (y) (Blank). ~~Children's Mental Health. Nothing in this~~
8 ~~Section shall suspend the screening and assessment~~
9 ~~requirements for mental health services for children~~
10 ~~participating in the State's medical assistance program as~~
11 ~~required in Section 5-5.23 of the Illinois Public Aid Code.~~

12 (Source: P.A. 102-558, eff. 8-20-21; 102-579, eff. 1-1-22;
13 102-813, eff. 5-13-22; 103-426, eff. 8-4-23; 103-650, eff.
14 1-1-25; 103-1040, eff. 8-9-24; revised 11-26-24.)

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

17 (215 ILCS 124/10)

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

19 Sec. 10. Network adequacy.

20 (a) Before issuing, delivering, or renewing a network
21 plan, an issuer 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

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

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

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

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

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

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

25 (2) As deemed necessary by the Department, the names,
26 addresses, phone numbers, and specialties of the providers

1 who have entered into preferred provider agreements under
2 the network plan.

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

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

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

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

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

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

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

1 applicable.

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

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

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

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

1 cost sharing provisions.

2 (9) For a network plan to be offered through the
3 Exchange in the individual or small group market, as well
4 as any off-Exchange mirror of such a network plan,
5 evidence that the network plan includes essential
6 community providers in accordance with rules established
7 by the Exchange that will operate in this State for the
8 applicable plan year.

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

12 (1) The minimum ratio of physicians or other providers
13 to plan beneficiaries shall be established 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, except to the extent provided under federal law
20 for stand-alone dental plans. The Department shall
21 consider establishing ratios for the following physicians
22 or other providers:

23 (A) Primary Care;

24 (B) Pediatrics;

25 (C) Cardiology;

26 (D) Gastroenterology;

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

1 review of the adequacy of these standards, along with an
2 assessment of additional specialties to be included in the
3 list under this subsection (c).

4 (3) Notwithstanding any other law or rule, the minimum
5 ratio for each provider type shall be no less than any such
6 ratio established for qualified health plans in
7 Federally-Facilitated Exchanges by federal law or by the
8 federal Centers for Medicare and Medicaid Services, even
9 if the network plan is issued in the large group market or
10 is otherwise not issued through an exchange. Federal
11 standards for stand-alone dental plans shall only apply to
12 such network plans. In the absence of an applicable
13 Department rule, the federal standards shall apply for the
14 time period specified in the federal law, regulation, or
15 guidance. If the Centers for Medicare and Medicaid
16 Services establish standards that are more stringent than
17 the standards in effect under any Department rule, the
18 Department may amend its rules to conform to the more
19 stringent federal standards.

20 (d) The network plan shall demonstrate to the Director
21 maximum travel and distance standards and appointment wait
22 time standards for plan beneficiaries, which shall be
23 established by the Department in consultation with the
24 Department of Public Health based upon the guidance from the
25 federal Centers for Medicare and Medicaid Services. These
26 standards shall consist of the maximum minutes or miles to be

1 traveled by a plan beneficiary for each county type, such as
2 large counties, metro counties, or rural counties as defined
3 by Department rule.

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

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

11 Notwithstanding any other law or Department rule, the
12 maximum travel time and distance standards and appointment
13 wait time standards shall be no greater than any such
14 standards established for qualified health plans in
15 Federally-Facilitated Exchanges by federal law or by the
16 federal Centers for Medicare and Medicaid Services, even if
17 the network plan is issued in the large group market or is
18 otherwise not issued through an exchange. Federal standards
19 for stand-alone dental plans shall only apply to such network
20 plans. In the absence of an applicable Department rule, the
21 federal standards shall apply for the time period specified in
22 the federal law, regulation, or guidance. If the Centers for
23 Medicare and Medicaid Services establish standards that are
24 more stringent than the standards in effect under any
25 Department rule, the Department may amend its rules to conform
26 to the more stringent federal standards.

1 If the federal area designations for the maximum time or
2 distance or appointment wait time standards required are
3 changed by the most recent Letter to Issuers in the
4 Federally-facilitated Marketplaces, the Department shall post
5 on its website notice of such changes and may amend its rules
6 to conform to those designations if the Director deems
7 appropriate.

8 (d-5) (1) Every issuer shall ensure that beneficiaries have
9 timely and proximate access to treatment for mental,
10 emotional, nervous, or substance use disorders or conditions
11 in accordance with the provisions of paragraph (4) of
12 subsection (a) of Section 370c of the Illinois Insurance Code.
13 Issuers shall use a comparable process, strategy, evidentiary
14 standard, and other factors in the development and application
15 of the network adequacy standards for timely and proximate
16 access to treatment for mental, emotional, nervous, or
17 substance use disorders or conditions and those for the access
18 to treatment for medical and surgical conditions. As such, the
19 network adequacy standards for timely and proximate access
20 shall equally be applied to treatment facilities and providers
21 for mental, emotional, nervous, or substance use disorders or
22 conditions and specialists providing medical or surgical
23 benefits pursuant to the parity requirements of Section 370c.1
24 of the Illinois Insurance Code and the federal Paul Wellstone
25 and Pete Domenici Mental Health Parity and Addiction Equity
26 Act of 2008. Notwithstanding the foregoing, the network

1 adequacy standards for timely and proximate access to
2 treatment for mental, emotional, nervous, or substance use
3 disorders or conditions shall, at a minimum, satisfy the
4 following requirements:

5 (A) For beneficiaries residing in the metropolitan
6 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
7 network adequacy standards for timely and proximate access
8 to treatment for mental, emotional, nervous, or substance
9 use disorders or conditions means a beneficiary shall not
10 have to travel longer than 30 minutes or 30 miles from the
11 beneficiary's residence to receive outpatient treatment
12 for mental, emotional, nervous, or substance use disorders
13 or conditions. Beneficiaries shall not be required to wait
14 longer than 10 business days between requesting an initial
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment or to wait longer than
18 20 business days between requesting a repeat or follow-up
19 appointment and being seen by the facility or provider of
20 mental, emotional, nervous, or substance use disorders or
21 conditions for outpatient treatment; however, subject to
22 the protections of paragraph (3) of this subsection, a
23 network plan shall not be held responsible if the
24 beneficiary or provider voluntarily chooses to schedule an
25 appointment outside of these required time frames.

26 (B) For beneficiaries residing in Illinois counties

1 other than those counties listed in subparagraph (A) of
2 this paragraph, network adequacy standards for timely and
3 proximate access to treatment for mental, emotional,
4 nervous, or substance use disorders or conditions means a
5 beneficiary shall not have to travel longer than 60
6 minutes or 60 miles from the beneficiary's residence to
7 receive outpatient treatment for mental, emotional,
8 nervous, or substance use disorders or conditions.
9 Beneficiaries shall not be required to wait longer than 10
10 business days between requesting an initial appointment
11 and being seen by the facility or provider of mental,
12 emotional, nervous, or substance use disorders or
13 conditions for outpatient treatment or to wait longer than
14 20 business days between requesting a repeat or follow-up
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment; however, subject to
18 the protections of paragraph (3) of this subsection, a
19 network plan shall not be held responsible if the
20 beneficiary or provider voluntarily chooses to schedule an
21 appointment outside of these required time frames.

22 (2) For beneficiaries residing in all Illinois counties,
23 network adequacy standards for timely and proximate access to
24 treatment for mental, emotional, nervous, or substance use
25 disorders or conditions means a beneficiary shall not have to
26 travel longer than 60 minutes or 60 miles from the

1 beneficiary's residence to receive inpatient or residential
2 treatment for mental, emotional, nervous, or substance use
3 disorders or conditions.

4 (3) If there is no in-network facility or provider
5 available for a beneficiary to receive timely and proximate
6 access to treatment for mental, emotional, nervous, or
7 substance use disorders or conditions in accordance with the
8 network adequacy standards outlined in this subsection, the
9 issuer shall provide necessary exceptions to its network to
10 ensure admission and treatment with a provider or at a
11 treatment facility in accordance with the network adequacy
12 standards in this subsection at the in-network benefit level.

13 (A) For plan or policy years beginning on or after
14 January 1, 2026, the issuer also shall provide reasonable
15 reimbursement to a beneficiary who has received an
16 exception as outlined in this paragraph (3) for costs
17 including food, lodging, and travel.

18 (i) Reimbursement for food and lodging shall be at
19 the prevailing federal per diem rates then in effect,
20 as set by the United States General Services
21 Administration. Reimbursement for travel by vehicle
22 shall be reimbursed at the current Internal Revenue
23 Service mileage standard for miles driven for
24 transportation or travel expenses.

25 (ii) At the time an issuer grants an exception
26 under this paragraph (3), the issuer shall give

1 written notification to the beneficiary of potential
2 eligibility for reimbursement under this subparagraph
3 (A) and instructions on how to file a claim for such
4 reimbursement, including a link to the claim form on
5 the issuer's public website and a phone number for a
6 beneficiary to request that the issuer send a hard
7 copy of the claim form by postal mail. The Department
8 shall create the template for the reimbursement
9 notification form, which issuers shall fill in and
10 post on their public website.

11 (iii) An issuer may require a beneficiary to
12 submit a claim for food, travel, or lodging
13 reimbursement within 60 days of the last date of the
14 health care service for which travel was undertaken,
15 and the beneficiary may appeal any denial of
16 reimbursement claims.

17 (iv) An issuer may deny reimbursement for food,
18 lodging, and travel if the provider's site of care is
19 neither within this State nor within 100 miles of the
20 beneficiary's residence unless, after a good faith
21 effort, no provider can be found who is available
22 within those parameters to provide the medically
23 necessary health care service within 10 business days
24 after a request for appointment.

25 (B) Notwithstanding any other provision of this
26 Section to the contrary, subparagraph (A) of this

1 paragraph (3) does not apply to policies issued or
2 delivered in this State that provide medical assistance
3 under the Illinois Public Aid Code or the Children's
4 Health Insurance Program Act.

5 (4) If the federal Centers for Medicare and Medicaid
6 Services establishes or law requires more stringent standards
7 for qualified health plans in the Federally-Facilitated
8 Exchanges, the federal standards shall control for all network
9 plans for the time period specified in the federal law,
10 regulation, or guidance, even if the network plan is issued in
11 the large group market, is issued through a different type of
12 Exchange, or is otherwise not issued through an Exchange.

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

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

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

1 following circumstances:

2 (1) if no providers or facilities meet the specific
3 time and distance standard in a specific service area and
4 the issuer (i) discloses information on the distance and
5 travel time points that beneficiaries would have to travel
6 beyond the required criterion to reach the next closest
7 contracted provider outside of the service area and (ii)
8 provides contact information, including names, addresses,
9 and phone numbers for the next closest contracted provider
10 or facility;

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

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

20 (h) Issuers are required to report to the Director any
21 material change to an approved network plan within 15 business
22 days after the change occurs and any change that would result
23 in failure to meet the requirements of this Act. The issuer
24 shall submit a revised version of the portions of the network
25 adequacy filing affected by the material change, as determined
26 by the Director by rule, and the issuer shall attach versions

1 with the changes indicated for each document that was revised
2 from the previous version of the filing. Upon notice from the
3 issuer, the Director shall reevaluate the network plan's
4 compliance with the network adequacy and transparency
5 standards of this Act. For every day past 15 business days that
6 the issuer fails to submit a revised network adequacy filing
7 to the Director, the Director may order a fine of \$5,000 per
8 day.

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

20 (j) If the Director determines that a network is
21 inadequate in any county and no exception has been granted
22 under subsection (g) and the issuer does not have a process in
23 place to comply with subsection (d-5), the Director may
24 prohibit the network plan from being issued or renewed within
25 that county until the Director determines that the network is
26 adequate apart from processes and exceptions described in

1 subsections (d-5) and (g). Nothing in this subsection shall be
2 construed to terminate any beneficiary's health insurance
3 coverage under a network plan before the expiration of the
4 beneficiary's policy period if the Director makes a
5 determination under this subsection after the issuance or
6 renewal of the beneficiary's policy or certificate because of
7 a material change. Policies or certificates issued or renewed
8 in violation of this subsection may subject the issuer to a
9 civil penalty of \$5,000 per policy.

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

15 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
16 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

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

18 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (6) A provision ensuring that whenever a beneficiary
25 has made a good faith effort, as evidenced by accessing
26 the provider directory, calling the network plan, and

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

1 shall a beneficiary who receives care at a participating
2 health care facility be required to search for
3 participating providers under the circumstances described
4 in subsection (b) or (b-5) of Section 356z.3a of the
5 Illinois Insurance Code except under the circumstances
6 described in paragraph (2) of subsection (b-5).

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

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

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

25 (1) The ratio of physicians or other providers to plan
26 beneficiaries shall be established annually by the

1 Department in consultation with the Department of Public
2 Health based upon the guidance from the federal Centers
3 for Medicare and Medicaid Services. The Department shall
4 not establish ratios for vision or dental providers who
5 provide services under dental-specific or vision-specific
6 benefits. The Department shall consider establishing
7 ratios for the following physicians 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.

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

24 The maximum travel time and distance standards must
25 include standards for each physician and other provider
26 category listed for which ratios have been established.

1 The Director shall establish a process for the review of
2 the adequacy of these standards along with an assessment of
3 additional specialties to be included in the list under this
4 subsection (d).

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

1 following requirements:

2 (A) For beneficiaries residing in the metropolitan
3 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
4 network adequacy standards for timely and proximate access
5 to treatment for mental, emotional, nervous, or substance
6 use disorders or conditions means a beneficiary shall not
7 have to travel longer than 30 minutes or 30 miles from the
8 beneficiary's residence to receive outpatient treatment
9 for mental, emotional, nervous, or substance use disorders
10 or conditions. Beneficiaries shall not be required to wait
11 longer than 10 business days between requesting an initial
12 appointment and being seen by the facility or provider of
13 mental, emotional, nervous, or substance use disorders or
14 conditions for outpatient treatment or to wait longer than
15 20 business days between requesting a repeat or follow-up
16 appointment and being seen by the facility or provider of
17 mental, emotional, nervous, or substance use disorders or
18 conditions for outpatient treatment; however, subject to
19 the protections of paragraph (3) of this subsection, a
20 network plan shall not be held responsible if the
21 beneficiary or provider voluntarily chooses to schedule an
22 appointment outside of these required time frames.

23 (B) For beneficiaries residing in Illinois counties
24 other than those counties listed in subparagraph (A) of
25 this paragraph, network adequacy standards for timely and
26 proximate access to treatment for mental, emotional,

1 nervous, or substance use disorders or conditions means a
2 beneficiary shall not have to travel longer than 60
3 minutes or 60 miles from the beneficiary's residence to
4 receive outpatient treatment for mental, emotional,
5 nervous, or substance use disorders or conditions.
6 Beneficiaries shall not be required to wait longer than 10
7 business days between requesting an initial appointment
8 and being seen by the facility or provider of mental,
9 emotional, nervous, or substance use disorders or
10 conditions for outpatient treatment or to wait longer than
11 20 business days between requesting a repeat or follow-up
12 appointment and being seen by the facility or provider of
13 mental, emotional, nervous, or substance use disorders or
14 conditions for outpatient treatment; however, subject to
15 the protections of paragraph (3) of this subsection, a
16 network plan shall not be held responsible if the
17 beneficiary or provider voluntarily chooses to schedule an
18 appointment outside of these required time frames.

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

1 (3) If there is no in-network facility or provider
2 available for a beneficiary to receive timely and proximate
3 access to treatment for mental, emotional, nervous, or
4 substance use disorders or conditions in accordance with the
5 network adequacy standards outlined in this subsection, the
6 insurer shall provide necessary exceptions to its network to
7 ensure admission and treatment with a provider or at a
8 treatment facility in accordance with the network adequacy
9 standards in this subsection at the in-network benefit level.

10 (A) For plan or policy years beginning on or after
11 January 1, 2026, the issuer also shall provide reasonable
12 reimbursement to a beneficiary who has received an
13 exception as outlined in this paragraph (3) for costs
14 including food, lodging, and travel.

15 (i) Reimbursement for food and lodging shall be at
16 the prevailing federal per diem rates then in effect,
17 as set by the United States General Services
18 Administration. Reimbursement for travel by vehicle
19 shall be reimbursed at the current Internal Revenue
20 Service mileage standard for miles driven for
21 transportation or travel expenses.

22 (ii) At the time an issuer grants an exception
23 under this paragraph (3), the issuer shall give
24 written notification to the beneficiary of potential
25 eligibility for reimbursement under this subparagraph
26 (A) and instructions on how to file a claim for such

1 reimbursement, including a link to the claim form on
2 the issuer's public website and a phone number for a
3 beneficiary to request that the issuer send a hard
4 copy of the claim form by postal mail. The Department
5 shall create the template for the reimbursement
6 notification form, which issuers shall fill in and
7 post on their public website.

8 (iii) An issuer may require a beneficiary to
9 submit a claim for food, travel, or lodging
10 reimbursement within 60 days of the last date of the
11 health care service for which travel was undertaken,
12 and the beneficiary may appeal any denial of
13 reimbursement claims.

14 (iv) An issuer may deny reimbursement for food,
15 lodging, and travel if the provider's site of care is
16 neither within this State nor within 100 miles of the
17 beneficiary's residence unless, after a good faith
18 effort, no provider can be found who is available
19 within those parameters to provide the medically
20 necessary health care service within 10 business days
21 of a request for appointment.

22 (B) Notwithstanding any other provision of this
23 Section to the contrary, subparagraph (A) of this
24 paragraph (3) does not apply to policies issued or
25 delivered in this State that provide medical assistance
26 under the Illinois Public Aid Code or the Children's

1 Health Insurance Program Act.

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

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

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

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

25 (2) if patterns of care in the service area do not
26 support the need for the requested number of provider or

1 facility type and the insurer provides data on local
2 patterns of care, such as claims data, referral patterns,
3 or local provider interviews, indicating where the
4 beneficiaries currently seek this type of care or where
5 the physicians currently refer beneficiaries, or both; or

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

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

15 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
16 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

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

18 Sec. 10. Network adequacy.

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

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

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

3 (3) The written policies and procedures on how the
4 network plan will provide 24-hour, 7-day per week access
5 to network-affiliated primary care, emergency services,
6 and obstetrical and gynecological health care
7 professionals.

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

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

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

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

26 (3) The number of beneficiaries anticipated to be

1 covered by the network plan.

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

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

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

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

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

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

25 (6) A provision ensuring that whenever a beneficiary
26 has made a good faith effort, as evidenced by accessing

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

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

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

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

25 (c) The network plan shall demonstrate to the Director a
26 minimum ratio of providers to plan beneficiaries as required

1 by the Department.

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

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

- 1 (Q) Infectious Disease;
2 (R) Nephrology;
3 (S) Neurosurgery;
4 (T) Orthopedic Surgery;
5 (U) Physiatry/Rehabilitative;
6 (V) Plastic Surgery;
7 (W) Pulmonary;
8 (X) Rheumatology;
9 (Y) Anesthesiology;
10 (Z) Pain Medicine;
11 (AA) Pediatric Specialty Services;
12 (BB) Outpatient Dialysis; and
13 (CC) HIV.

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

18 (d) The network plan shall demonstrate to the Director
19 maximum travel and distance standards for plan beneficiaries,
20 which shall be established annually by the Department in
21 consultation with the Department of Public Health based upon
22 the guidance from the federal Centers for Medicare and
23 Medicaid Services. These standards shall consist of the
24 maximum minutes or miles to be traveled by a plan beneficiary
25 for each county type, such as large counties, metro counties,
26 or rural counties as defined by Department rule.

1 The maximum travel time and distance standards must
2 include standards for each physician and other provider
3 category listed for which ratios have been established.

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

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

1 adequacy standards for timely and proximate access to
2 treatment for mental, emotional, nervous, or substance use
3 disorders or conditions shall, at a minimum, satisfy the
4 following requirements:

5 (A) For beneficiaries residing in the metropolitan
6 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
7 network adequacy standards for timely and proximate access
8 to treatment for mental, emotional, nervous, or substance
9 use disorders or conditions means a beneficiary shall not
10 have to travel longer than 30 minutes or 30 miles from the
11 beneficiary's residence to receive outpatient treatment
12 for mental, emotional, nervous, or substance use disorders
13 or conditions. Beneficiaries shall not be required to wait
14 longer than 10 business days between requesting an initial
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment or to wait longer than
18 20 business days between requesting a repeat or follow-up
19 appointment and being seen by the facility or provider of
20 mental, emotional, nervous, or substance use disorders or
21 conditions for outpatient treatment; however, subject to
22 the protections of paragraph (3) of this subsection, a
23 network plan shall not be held responsible if the
24 beneficiary or provider voluntarily chooses to schedule an
25 appointment outside of these required time frames.

26 (B) For beneficiaries residing in Illinois counties

1 other than those counties listed in subparagraph (A) of
2 this paragraph, network adequacy standards for timely and
3 proximate access to treatment for mental, emotional,
4 nervous, or substance use disorders or conditions means a
5 beneficiary shall not have to travel longer than 60
6 minutes or 60 miles from the beneficiary's residence to
7 receive outpatient treatment for mental, emotional,
8 nervous, or substance use disorders or conditions.
9 Beneficiaries shall not be required to wait longer than 10
10 business days between requesting an initial appointment
11 and being seen by the facility or provider of mental,
12 emotional, nervous, or substance use disorders or
13 conditions for outpatient treatment or to wait longer than
14 20 business days between requesting a repeat or follow-up
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment; however, subject to
18 the protections of paragraph (3) of this subsection, a
19 network plan shall not be held responsible if the
20 beneficiary or provider voluntarily chooses to schedule an
21 appointment outside of these required time frames.

22 (2) For beneficiaries residing in all Illinois counties,
23 network adequacy standards for timely and proximate access to
24 treatment for mental, emotional, nervous, or substance use
25 disorders or conditions means a beneficiary shall not have to
26 travel longer than 60 minutes or 60 miles from the

1 beneficiary's residence to receive inpatient or residential
2 treatment for mental, emotional, nervous, or substance use
3 disorders or conditions.

4 (3) If there is no in-network facility or provider
5 available for a beneficiary to receive timely and proximate
6 access to treatment for mental, emotional, nervous, or
7 substance use disorders or conditions in accordance with the
8 network adequacy standards outlined in this subsection, the
9 insurer shall provide necessary exceptions to its network to
10 ensure admission and treatment with a provider or at a
11 treatment facility in accordance with the network adequacy
12 standards in this subsection at the in-network benefit level.

13 (A) For plan or policy years beginning on or after
14 January 1, 2026, the issuer also shall provide reasonable
15 reimbursement to a beneficiary who has received an
16 exception as outlined in this paragraph (3) for costs
17 including food, lodging, and travel.

18 (i) Reimbursement for food and lodging shall be at
19 the prevailing federal per diem rates then in effect,
20 as set by the United States General Services
21 Administration. Reimbursement for travel by vehicle
22 shall be reimbursed at the current Internal Revenue
23 Service mileage standard for miles driven for
24 transportation or travel expenses.

25 (ii) At the time an issuer grants an exception
26 under this paragraph (3), the issuer shall give

1 written notification to the beneficiary of potential
2 eligibility for reimbursement under this subparagraph
3 (A) and instructions on how to file a claim for such
4 reimbursement, including a link to the claim form on
5 the issuer's public website and a phone number for a
6 beneficiary to request that the issuer send a hard
7 copy of the claim form by postal mail. The Department
8 shall create the template for the reimbursement
9 notification form, which issuers shall fill in and
10 post on their public website.

11 (iii) An issuer may require a beneficiary to
12 submit a claim for food, travel, or lodging
13 reimbursement within 60 days of the last date of the
14 health care service for which travel was undertaken,
15 and the beneficiary may appeal any denial of
16 reimbursement claims.

17 (iv) An issuer may deny reimbursement for food,
18 lodging, and travel if the provider's site of care is
19 neither within this State nor within 100 miles of the
20 beneficiary's residence unless, after a good faith
21 effort, no provider can be found who is available
22 within those parameters to provide the medically
23 necessary health care service within 10 business days
24 of a request for appointment.

25 (B) Notwithstanding any other provision of this
26 Section to the contrary, subparagraph (A) of this

1 paragraph (3) does not apply to policies issued or
2 delivered in this State that provide medical assistance
3 under the Illinois Public Aid Code or the Children's
4 Health Insurance Program Act.

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

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

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

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

1 or facility;

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

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

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

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

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

21 Sec. 10. Network adequacy.

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

24 (1) The written policies and procedures for adding
25 providers to meet patient needs based on increases in the

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

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

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

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

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

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

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

1 the network plan.

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

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

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

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

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

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

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

1 (6) A provision ensuring that whenever a beneficiary
2 has made a good faith effort, as evidenced by accessing
3 the provider directory, calling the network plan, and
4 calling the provider, to utilize preferred providers for a
5 covered service and it is determined the insurer does not
6 have the appropriate preferred providers due to
7 insufficient number, type, unreasonable travel distance or
8 delay, or preferred providers refusing to provide a
9 covered service because it is contrary to the conscience
10 of the preferred providers, as protected by the Health
11 Care Right of Conscience Act, the insurer shall give the
12 beneficiary a network exception and shall ensure, directly
13 or indirectly, by terms contained in the payer contract,
14 that the beneficiary will be provided the covered service
15 at no greater cost to the beneficiary than if the service
16 had been provided by a preferred provider. This paragraph
17 (6) does not apply to: (A) a beneficiary who willfully
18 chooses to access a non-preferred provider for health care
19 services available through the panel of preferred
20 providers, or (B) a beneficiary enrolled in a health
21 maintenance organization, except that the health
22 maintenance organization must notify the beneficiary when
23 a referral has been granted as a network exception based
24 on any preferred provider access deficiency described in
25 this paragraph or under the circumstances applicable in
26 paragraph (3) of subsection (d-5). 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, except to the extent provided under federal law
12 for stand-alone dental plans. The Department shall
13 consider establishing ratios for the following physicians
14 or other providers:

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

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

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

22 (3) If the federal Centers for Medicare and Medicaid
23 Services establishes minimum provider ratios for
24 stand-alone dental plans in the type of exchange in use in
25 this State for a given plan year, the Department shall
26 enforce those standards for stand-alone dental plans for

1 that plan year.

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

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

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

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

1 the Department shall enforce those standards for stand-alone
2 dental plans for that plan year.

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

26 (A) For beneficiaries residing in the metropolitan

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

21 (B) For beneficiaries residing in Illinois counties
22 other than those counties listed in subparagraph (A) of
23 this paragraph, network adequacy standards for timely and
24 proximate access to treatment for mental, emotional,
25 nervous, or substance use disorders or conditions means a
26 beneficiary shall not have to travel longer than 60

1 minutes or 60 miles from the beneficiary's residence to
2 receive outpatient treatment for mental, emotional,
3 nervous, or substance use disorders or conditions.
4 Beneficiaries shall not be required to wait longer than 10
5 business days between requesting an initial appointment
6 and being seen by the facility or provider of mental,
7 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 (2) For beneficiaries residing in all Illinois counties,
18 network adequacy standards for timely and proximate access to
19 treatment for mental, emotional, nervous, or substance use
20 disorders or conditions means a beneficiary shall not have to
21 travel longer than 60 minutes or 60 miles from the
22 beneficiary's residence to receive inpatient or residential
23 treatment for mental, emotional, nervous, or substance use
24 disorders or conditions.

25 (3) If there is no in-network facility or provider
26 available for a beneficiary to receive timely and proximate

1 access to treatment for mental, emotional, nervous, or
2 substance use disorders or conditions in accordance with the
3 network adequacy standards outlined in this subsection, the
4 insurer shall provide necessary exceptions to its network to
5 ensure admission and treatment with a provider or at a
6 treatment facility in accordance with the network adequacy
7 standards in this subsection at the in-network benefit level.

8 (A) For plan or policy years beginning on or after
9 January 1, 2026, the issuer also shall provide reasonable
10 reimbursement to a beneficiary who has received an
11 exception as outlined in this paragraph (3) for costs
12 including food, lodging, and travel.

13 (i) Reimbursement for food and lodging shall be at
14 the prevailing federal per diem rates then in effect,
15 as set by the United States General Services
16 Administration. Reimbursement for travel by vehicle
17 shall be reimbursed at the current Internal Revenue
18 Service mileage standard for miles driven for
19 transportation or travel expenses.

20 (ii) At the time an issuer grants an exception
21 under this paragraph (3), the issuer shall give
22 written notification to the beneficiary of potential
23 eligibility for reimbursement under this subparagraph
24 (A) and instructions on how to file a claim for such
25 reimbursement, including a link to the claim form on
26 the issuer's public website and a phone number for a

1 beneficiary to request that the issuer send a hard
2 copy of the claim form by postal mail. The Department
3 shall create the template for the reimbursement
4 notification form, which issuers shall fill in and
5 post on their public website.

6 (iii) An issuer may require a beneficiary to
7 submit a claim for food, travel, or lodging
8 reimbursement within 60 days of the last date of the
9 health care service for which travel was undertaken,
10 and the beneficiary may appeal any denial of
11 reimbursement claims.

12 (iv) An issuer may deny reimbursement for food,
13 lodging, and travel if the provider's site of care is
14 neither within this State nor within 100 miles of the
15 beneficiary's residence unless, after a good faith
16 effort, no provider can be found who is available
17 within those parameters to provide the medically
18 necessary health care service within 10 business days
19 of a request for appointment.

20 (B) Notwithstanding any other provision of this
21 Section to the contrary, subparagraph (A) of this
22 paragraph (3) does not apply to policies issued or
23 delivered in this State that provide medical assistance
24 under the Illinois Public Aid Code or the Children's
25 Health Insurance Program Act.

26 (4) If the federal Centers for Medicare and Medicaid

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

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

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

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

23 (1) if no providers or facilities meet the specific
24 time and distance standard in a specific service area and
25 the insurer (i) discloses information on the distance and
26 travel time points that beneficiaries would have to travel

1 beyond the required criterion to reach the next closest
2 contracted provider outside of the service area and (ii)
3 provides contact information, including names, addresses,
4 and phone numbers for the next closest contracted provider
5 or facility;

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

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

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

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

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

25 Sec. 10. Network adequacy.

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

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

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

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

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

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

25 (1) A geographic map of the area proposed to be served
26 by the plan by county service area and zip code, including

1 marked locations for preferred providers.

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

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

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

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

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

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

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

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

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

1 a referral has been granted as a network exception based
2 on any preferred provider access deficiency described in
3 this paragraph or under the circumstances applicable in
4 paragraph (3) of subsection (d-5). In these circumstances,
5 the contractual requirements for non-preferred provider
6 reimbursements shall apply unless Section 356z.3a of the
7 Illinois Insurance Code requires otherwise. In no event
8 shall a beneficiary who receives care at a participating
9 health care facility be required to search for
10 participating providers under the circumstances described
11 in subsection (b) or (b-5) of Section 356z.3a of the
12 Illinois Insurance Code except under the circumstances
13 described in paragraph (2) of subsection (b-5).

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

26 (8) A limitation that, if the plan provides that the

1 beneficiary will incur a penalty for failing to
2 pre-certify inpatient hospital treatment, the penalty may
3 not exceed \$1,000 per occurrence in addition to the plan
4 cost sharing provisions.

5 (c) The network plan shall demonstrate to the Director a
6 minimum ratio of providers to plan beneficiaries as required
7 by the Department.

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

- 17 (A) Primary Care;
- 18 (B) Pediatrics;
- 19 (C) Cardiology;
- 20 (D) Gastroenterology;
- 21 (E) General Surgery;
- 22 (F) Neurology;
- 23 (G) OB/GYN;
- 24 (H) Oncology/Radiation;
- 25 (I) Ophthalmology;
- 26 (J) Urology;

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

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

1 in each in-network hospital in a network plan.

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

6 (d) The network plan shall demonstrate to the Director
7 maximum travel and distance standards for plan beneficiaries,
8 which shall be established annually by the Department in
9 consultation with the Department of Public Health based upon
10 the guidance from the federal Centers for Medicare and
11 Medicaid Services. These standards shall consist of the
12 maximum minutes or miles to be traveled by a plan beneficiary
13 for each county type, such as large counties, metro counties,
14 or rural counties as defined 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 (d-5)(1) Every insurer shall ensure that beneficiaries
23 have timely and proximate access to treatment for mental,
24 emotional, nervous, or substance use disorders or conditions
25 in accordance with the provisions of paragraph (4) of
26 subsection (a) of Section 370c of the Illinois Insurance Code.

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

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

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

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

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

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

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

1 (A) For plan or policy years beginning on or after
2 January 1, 2026, the issuer also shall provide reasonable
3 reimbursement to a beneficiary who has received an
4 exception as outlined in this paragraph (3) for costs
5 including food, lodging, and travel.

6 (i) Reimbursement for food and lodging shall be at
7 the prevailing federal per diem rates then in effect,
8 as set by the United States General Services
9 Administration. Reimbursement for travel by vehicle
10 shall be reimbursed at the current Internal Revenue
11 Service mileage standard for miles driven for
12 transportation or travel expenses.

13 (ii) At the time an issuer grants an exception
14 under this paragraph (3), the issuer shall give
15 written notification to the beneficiary of potential
16 eligibility for reimbursement under this subparagraph
17 (A) and instructions on how to file a claim for such
18 reimbursement, including a link to the claim form on
19 the issuer's public website and a phone number for a
20 beneficiary to request that the issuer send a hard
21 copy of the claim form by postal mail. The Department
22 shall create the template for the reimbursement
23 notification form, which issuers shall fill in and
24 post on their public website.

25 (iii) An issuer may require a beneficiary to
26 submit a claim for food, travel, or lodging

1 reimbursement within 60 days of the last date of the
2 health care service for which travel was undertaken,
3 and the beneficiary may appeal any denial of
4 reimbursement claims.

5 (iv) An issuer may deny reimbursement for food,
6 lodging, and travel if the provider's site of care is
7 neither within this State nor within 100 miles of the
8 beneficiary's residence unless, after a good faith
9 effort, no provider can be found who is available
10 within those parameters to provide the medically
11 necessary health care service within 10 business days
12 of a request for appointment.

13 (B) Notwithstanding any other provision of this
14 Section to the contrary, subparagraph (A) of this
15 paragraph (3) does not apply to policies issued or
16 delivered in this State that provide medical assistance
17 under the Illinois Public Aid Code or the Children's
18 Health Insurance Program Act.

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

22 (f) The network plan may consider use of other health care
23 service delivery options, such as telemedicine or telehealth,
24 mobile clinics, and centers of excellence, or other ways of
25 delivering care to partially meet the requirements set under
26 this Section.

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

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

16 (2) if patterns of care in the service area do not
17 support the need for the requested number of provider or
18 facility type and the insurer provides data on local
19 patterns of care, such as claims data, referral patterns,
20 or local provider interviews, indicating where the
21 beneficiaries currently seek this type of care or where
22 the physicians currently refer beneficiaries, or both; or

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

25 (h) Insurers are required to report to the Director any
26 material change to an approved network plan within 15 days

1 after the change occurs and any change that would result in
2 failure to meet the requirements of this Act. Upon notice from
3 the insurer, the Director shall reevaluate the network plan's
4 compliance with the network adequacy and transparency
5 standards of this Act.

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

8 Section 15. The Health Maintenance Organization Act is
9 amended by changing Section 5-3 as follows:

10 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

11 (Text of Section before amendment by P.A. 103-808)

12 Sec. 5-3. Insurance Code provisions.

13 (a) Health Maintenance Organizations shall be subject to
14 the provisions of Sections 133, 134, 136, 137, 139, 140,
15 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
16 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
17 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,
18 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
19 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
20 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
21 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
22 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
23 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
24 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,

1 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
2 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
3 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
4 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5,
5 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
6 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
7 paragraph (c) of subsection (2) of Section 367, and Articles
8 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
9 XXXIIB of the Illinois Insurance Code.

10 (b) For purposes of the Illinois Insurance Code, except
11 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
12 Health Maintenance Organizations in the following categories
13 are deemed to be "domestic companies":

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

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

18 (3) a corporation organized under the laws of another
19 state, 30% or more of the enrollees of which are residents
20 of this State, except a corporation subject to
21 substantially the same requirements in its state of
22 organization as is a "domestic company" under Article VIII
23 1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

25 (C) a pro forma business plan detailing an
26 acquiring party's plans with respect to the operation

1 of the Health Maintenance Organization sought to be
2 acquired for a period of not less than 3 years; and

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

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

11 (e) In considering any management contract or service
12 agreement subject to Section 141.1 of the Illinois Insurance
13 Code, the Director (i) shall, in addition to the criteria
14 specified in Section 141.2 of the Illinois Insurance Code,
15 take into account the effect of the management contract or
16 service agreement on the continuation of benefits to enrollees
17 and the financial condition of the health maintenance
18 organization to be managed or serviced, and (ii) need not take
19 into account the effect of the management contract or service
20 agreement on competition.

21 (f) Except for small employer groups as defined in the
22 Small Employer Rating, Renewability and Portability Health
23 Insurance Act and except for medicare supplement policies as
24 defined in Section 363 of the Illinois Insurance Code, a
25 Health Maintenance Organization may by contract agree with a
26 group or other enrollment unit to effect refunds or charge

1 additional premiums under the following terms and conditions:

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

8 (ii) the amount of the refund or additional premium
9 shall not exceed 20% of the Health Maintenance
10 Organization's profitable or unprofitable experience with
11 respect to the group or other enrollment unit for the
12 period (and, for purposes of a refund or additional
13 premium, the profitable or unprofitable experience shall
14 be calculated taking into account a pro rata share of the
15 Health Maintenance Organization's administrative and
16 marketing expenses, but shall not include any refund to be
17 made or additional premium to be paid pursuant to this
18 subsection (f)). The Health Maintenance Organization and
19 the group or enrollment unit may agree that the profitable
20 or unprofitable experience may be calculated taking into
21 account the refund period and the immediately preceding 2
22 plan years.

23 The Health Maintenance Organization shall include a
24 statement in the evidence of coverage issued to each enrollee
25 describing the possibility of a refund or additional premium,
26 and upon request of any group or enrollment unit, provide to

1 the group or enrollment unit a description of the method used
2 to calculate (1) the Health Maintenance Organization's
3 profitable experience with respect to the group or enrollment
4 unit and the resulting refund to the group or enrollment unit
5 or (2) the Health Maintenance Organization's unprofitable
6 experience with respect to the group or enrollment unit and
7 the resulting additional premium to be paid by the group or
8 enrollment unit.

9 In no event shall the Illinois Health Maintenance
10 Organization Guaranty Association be liable to pay any
11 contractual obligation of an insolvent organization to pay any
12 refund authorized under this Section.

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

19 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
20 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
21 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
22 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
23 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
24 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
25 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
26 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.

1 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
2 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
3 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
4 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
5 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
6 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.
7 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

8 (Text of Section after amendment by P.A. 103-808)

9 Sec. 5-3. Insurance Code provisions.

10 (a) Health Maintenance Organizations shall be subject to
11 the provisions of Sections 133, 134, 136, 137, 139, 140,
12 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
13 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
14 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,
15 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
16 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
17 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
18 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
19 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
20 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
21 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
22 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
23 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
24 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
25 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5,

1 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
2 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
3 paragraph (c) of subsection (2) of Section 367, and Articles
4 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
5 XXXIIB of the Illinois Insurance Code.

6 (b) For purposes of the Illinois Insurance Code, except
7 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
8 Health Maintenance Organizations in the following categories
9 are deemed to be "domestic companies":

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

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

14 (3) a corporation organized under the laws of another
15 state, 30% or more of the enrollees of which are residents
16 of this State, except a corporation subject to
17 substantially the same requirements in its state of
18 organization as is a "domestic company" under Article VIII
19 1/2 of the Illinois Insurance Code.

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

23 (1) the Director shall give primary consideration to
24 the continuation of benefits to enrollees and the
25 financial conditions of the acquired Health Maintenance
26 Organization after the merger, consolidation, or other

1 acquisition of control takes effect;

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

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

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

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

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

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

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

7 (e) In considering any management contract or service
8 agreement subject to Section 141.1 of the Illinois Insurance
9 Code, the Director (i) shall, in addition to the criteria
10 specified in Section 141.2 of the Illinois Insurance Code,
11 take into account the effect of the management contract or
12 service agreement on the continuation of benefits to enrollees
13 and the financial condition of the health maintenance
14 organization to be managed or serviced, and (ii) need not take
15 into account the effect of the management contract or service
16 agreement on competition.

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

24 (i) the amount of, and other terms and conditions with
25 respect to, the refund or additional premium are set forth
26 in the group or enrollment unit contract agreed in advance

1 of the period for which a refund is to be paid or
2 additional premium is to be charged (which period shall
3 not be less than one year); and

4 (ii) the amount of the refund or additional premium
5 shall not exceed 20% of the Health Maintenance
6 Organization's profitable or unprofitable experience with
7 respect to the group or other enrollment unit for the
8 period (and, for purposes of a refund or additional
9 premium, the profitable or unprofitable experience shall
10 be calculated taking into account a pro rata share of the
11 Health Maintenance Organization's administrative and
12 marketing expenses, but shall not include any refund to be
13 made or additional premium to be paid pursuant to this
14 subsection (f)). The Health Maintenance Organization and
15 the group or enrollment unit may agree that the profitable
16 or unprofitable experience may be calculated taking into
17 account the refund period and the immediately preceding 2
18 plan years.

19 The Health Maintenance Organization shall include a
20 statement in the evidence of coverage issued to each enrollee
21 describing the possibility of a refund or additional premium,
22 and upon request of any group or enrollment unit, provide to
23 the group or enrollment unit a description of the method used
24 to calculate (1) the Health Maintenance Organization's
25 profitable experience with respect to the group or enrollment
26 unit and the resulting refund to the group or enrollment unit

1 or (2) the Health Maintenance Organization's unprofitable
2 experience with respect to the group or enrollment unit and
3 the resulting additional premium to be paid by the group or
4 enrollment unit.

5 In no event shall the Illinois Health Maintenance
6 Organization Guaranty Association be liable to pay any
7 contractual obligation of an insolvent organization to pay any
8 refund authorized under this Section.

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

15 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
16 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
17 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
18 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
19 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
20 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
21 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
22 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
23 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
24 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
25 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
26 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,

1 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
2 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.
3 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
4 11-26-24.)

5 Section 20. The Voluntary Health Services Plans Act is
6 amended by changing Section 10 as follows:

7 (215 ILCS 165/10) (from Ch. 32, par. 604)

8 Sec. 10. Application of Insurance Code provisions. Health
9 services plan corporations and all persons interested therein
10 or dealing therewith shall be subject to the provisions of
11 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
12 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3,
13 355.7, 355b, 355d, 356g, 356g.5, 356g.5-1, 356m, 356q, 356r,
14 356t, 356u, 356u.10, 356v, 356w, 356x, 356y, 356z.1, 356z.2,
15 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
16 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18,
17 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
18 356z.32, 356z.32a, 356z.33, 356z.40, 356z.41, 356z.46,
19 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59,
20 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.71,
21 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408,
22 408.2, and 412, and paragraphs (7) and (15) of Section 367 of
23 the Illinois Insurance Code.

24 Rulemaking authority to implement Public Act 95-1045, if

1 any, is conditioned on the rules being adopted in accordance
2 with all provisions of the Illinois Administrative Procedure
3 Act and all rules and procedures of the Joint Committee on
4 Administrative Rules; any purported rule not so adopted, for
5 whatever reason, is unauthorized.

6 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
7 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff.
8 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,
9 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;
10 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff.
11 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
12 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
13 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-656, eff.
14 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753,
15 eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25;
16 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff.
17 1-1-25; revised 11-26-24.)

18 Section 25. The Illinois Public Aid Code is amended by
19 changing Section 5-5.28 as follows:

20 (305 ILCS 5/5-5.28 new)

21 Sec. 5-5.28. Rulemaking authority. The Department of
22 Healthcare and Family Services may adopt rules to implement
23 the applicable provisions of this amendatory Act of the 104th
24 General Assembly to managed care organizations, managed care

1 community networks, and, at the Department's discretion, any
2 other managed care entity described in subsection (i) of
3 Section 5-30 of the Illinois Public Aid Code and the medical
4 assistance fee-for-service program.

5 Section 95. No acceleration or delay. Where this Act makes
6 changes in a statute that is represented in this Act by text
7 that is not yet or no longer in effect (for example, a Section
8 represented by multiple versions), the use of that text does
9 not accelerate or delay the taking effect of (i) the changes
10 made by this Act or (ii) provisions derived from any other
11 Public Act.

12 Section 99. Effective date. This Act takes effect January
13 1, 2026.