



Sen. Laura Fine

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10400HB3019sam002

LRB104 07095 BAB 26980 a

1 AMENDMENT TO HOUSE BILL 3019

2 AMENDMENT NO. _____. Amend House Bill 3019, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

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

8 (215 ILCS 5/355.7 new)

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

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

1 collections or receipts for risk adjustment and risk corridors
2 and payments of reinsurance, that such coverage expends:

3 (1) on reimbursement for clinical services provided to
4 enrollees under such coverage;

5 (2) for activities that improve health care quality;
6 and

7 (3) on all other non-claims costs, including an
8 explanation of the nature of such costs, and excluding
9 federal and State taxes and licensing or regulatory fees.

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

17 (c) If 42 U.S.C. 300gg-18 or the federal regulations
18 promulgated thereunder are amended after January 15, 2025 to
19 repeal the reporting or rebate requirements, reduce the amount
20 or types of information required to be reported, or adopt a
21 calculation method that reduces the amount of rebates in this
22 State, a health insurance issuer shall file a supplemental
23 report with the Director or make supplemental rebate payments,
24 as applicable, for group or individual health insurance
25 coverage regulated by this State to ensure that the same total
26 information is filed with the Director and the same total

1 rebates are remitted to enrollees as before the federal
2 repeal, reduction, or recalculation took effect.

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

6 (1) executive compensation beyond base salary;

7 (2) entity surplus or accumulated profit; or

8 (3) costs attendant with an application for lifestyle
9 management, weight loss, or wellness when the application
10 falls outside the scope of 45 CFR 158.140 through 158.160.

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

13 (f) Notwithstanding anything in this Section to the
14 contrary, this Section does not apply to policies issued or
15 delivered in this State that provide medical assistance under
16 the Illinois Public Aid Code or the Children's Health
17 Insurance Program Act.

18 (215 ILCS 5/356z.14)

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

20 (a) A group or individual policy of accident and health
21 insurance or managed care plan amended, delivered, issued, or
22 renewed after December 12, 2008 (the effective date of Public
23 Act 95-1005) must provide individuals under 21 years of age
24 coverage for the diagnosis of autism spectrum disorders and
25 for the treatment of autism spectrum disorders to the extent

1 that the diagnosis and treatment of autism spectrum disorders
2 are not already covered by the policy of accident and health
3 insurance or managed care plan.

4 (b) Coverage provided under this Section shall be subject
5 to a maximum benefit of \$36,000 per year, but shall not be
6 subject to any limits on the number of visits to a service
7 provider. ~~The After December 30, 2009, the~~ Director of ~~the~~
8 ~~Division of~~ Insurance shall, on an annual basis, adjust the
9 maximum benefit for inflation using the Medical Care Component
10 of the United States Department of Labor Consumer Price Index
11 for All Urban Consumers. Payments made by an insurer on behalf
12 of a covered individual for any care, treatment, intervention,
13 service, or item, the provision of which was for the treatment
14 of a health condition not diagnosed as an autism spectrum
15 disorder, shall not be applied toward any maximum benefit
16 established under this subsection.

17 (c) Coverage under this Section shall be subject to
18 copayment, deductible, and coinsurance provisions of a policy
19 of accident and health insurance or managed care plan to the
20 extent that other medical services covered by the policy of
21 accident and health insurance or managed care plan are subject
22 to these provisions.

23 (d) This Section shall not be construed as limiting
24 benefits that are otherwise available to an individual under a
25 policy of accident and health insurance or managed care plan
26 and benefits provided under this Section may not be subject to

1 dollar limits, deductibles, copayments, or coinsurance
2 provisions that are less favorable to the insured than the
3 dollar limits, deductibles, or coinsurance provisions that
4 apply to physical illness generally.

5 (e) An insurer may not deny or refuse to provide otherwise
6 covered services, or refuse to renew, refuse to reissue, or
7 otherwise terminate or restrict coverage under an individual
8 contract to provide services to an individual because the
9 individual or the individual's ~~their~~ dependent is diagnosed
10 with an autism spectrum disorder or due to the individual
11 utilizing benefits in this Section.

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

17 (f) Upon request of the ~~reimbursing~~ insurer, a provider of
18 treatment for autism spectrum disorders shall furnish medical
19 records, clinical notes, or other necessary data that
20 substantiate that initial or continued medical treatment is
21 medically necessary and is resulting in improved clinical
22 status. When treatment is anticipated to require continued
23 services to achieve demonstrable progress, the insurer may
24 request a treatment plan consisting of diagnosis, proposed
25 treatment by type, frequency, anticipated duration of
26 treatment, the anticipated outcomes stated as goals, and the

1 frequency by which the treatment plan will be updated. Nothing
2 in this subsection supersedes the prohibition on prior
3 authorization for mental health treatment under subsection (w)
4 of Section 370c.

5 (g) When making a determination of medical necessity for a
6 treatment modality for autism spectrum disorders, an insurer
7 must make the determination in a manner that is consistent
8 with the manner used to make that determination with respect
9 to other diseases or illnesses covered under the policy,
10 including an appeals process. During the appeals process, any
11 challenge to medical necessity must be viewed as reasonable
12 only if the review includes a physician with expertise in the
13 most current and effective treatment modalities for autism
14 spectrum disorders.

15 (h) Coverage for medically necessary early intervention
16 services must be delivered by certified early intervention
17 specialists, as defined in 89 Ill. Adm. Code 500 and any
18 subsequent amendments thereto.

19 (h-5) If an individual has been diagnosed as having an
20 autism spectrum disorder, meeting the diagnostic criteria in
21 place at the time of diagnosis, and treatment is determined
22 medically necessary, then that individual shall remain
23 eligible for coverage under this Section even if subsequent
24 changes to the diagnostic criteria are adopted by the American
25 Psychiatric Association. If no changes to the diagnostic
26 criteria are adopted after April 1, 2012, and before December

1 31, 2014, then this subsection (h-5) shall be of no further
2 force and effect.

3 (h-10) An insurer may not deny or refuse to provide
4 covered services, or refuse to renew, refuse to reissue, or
5 otherwise terminate or restrict coverage under an individual
6 contract, for a person diagnosed with an autism spectrum
7 disorder on the basis that the individual declined an
8 alternative medication or covered service when the
9 individual's health care provider has determined that such
10 medication or covered service may exacerbate clinical
11 symptomatology and is medically contraindicated for the
12 individual and the individual has requested and received a
13 medical exception as provided for under Section 45.1 of the
14 Managed Care Reform and Patient Rights Act. For the purposes
15 of this subsection (h-10), "clinical symptomatology" means any
16 indication of disorder or disease when experienced by an
17 individual as a change from normal function, sensation, or
18 appearance.

19 (h-15) If, at any time, the Secretary of the United States
20 Department of Health and Human Services, or its successor
21 agency, promulgates rules or regulations to be published in
22 the Federal Register or publishes a comment in the Federal
23 Register or issues an opinion, guidance, or other action that
24 would require the State, pursuant to any provision of the
25 Patient Protection and Affordable Care Act (Public Law
26 111-148), including, but not limited to, 42 U.S.C.

1 18031(d)(3)(B) or any successor provision, to defray the cost
2 of any coverage outlined in subsection (h-10), then subsection
3 (h-10) is inoperative with respect to all coverage outlined in
4 subsection (h-10) other than that authorized under Section
5 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State
6 shall not assume any obligation for the cost of the coverage
7 set forth in subsection (h-10).

8 (i) As used in this Section:

9 "Autism spectrum disorders" means pervasive developmental
10 disorders as defined in the most recent edition of the
11 Diagnostic and Statistical Manual of Mental Disorders,
12 including autism, Asperger's disorder, and pervasive
13 developmental disorder not otherwise specified.

14 "Diagnosis of autism spectrum disorders" means one or more
15 tests, evaluations, or assessments to diagnose whether an
16 individual has autism spectrum disorder that is prescribed,
17 performed, or ordered by (A) a physician licensed to practice
18 medicine in all its branches or (B) a licensed clinical
19 psychologist with expertise in diagnosing autism spectrum
20 disorders.

21 "Medically necessary" means any care, treatment,
22 intervention, service, or item which will or is reasonably
23 expected to do any of the following: (i) prevent the onset of
24 an illness, condition, injury, disease, or disability; (ii)
25 reduce or ameliorate the physical, mental, or developmental
26 effects of an illness, condition, injury, disease, or

1 disability; or (iii) assist to achieve or maintain maximum
2 functional activity in performing daily activities.

3 "Treatment for autism spectrum disorders" shall include
4 the following care prescribed, provided, or ordered for an
5 individual diagnosed with an autism spectrum disorder by (A) a
6 physician licensed to practice medicine in all its branches or
7 (B) a certified, registered, or licensed health care
8 professional with expertise in treating effects of autism
9 spectrum disorders when the care is determined to be medically
10 necessary and ordered by a physician licensed to practice
11 medicine in all its branches:

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

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

16 (3) Habilitative or rehabilitative care, meaning
17 professional, counseling, and guidance services and
18 treatment programs, including applied behavior analysis,
19 that are intended to develop, maintain, and restore the
20 functioning of an individual. As used in this subsection
21 (i), "applied behavior analysis" means the design,
22 implementation, and evaluation of environmental
23 modifications using behavioral stimuli and consequences to
24 produce socially significant improvement in human
25 behavior, including the use of direct observation,
26 measurement, and functional analysis of the relations

1 between environment and behavior.

2 (4) Therapeutic care, including behavioral, speech,
3 occupational, and physical therapies that provide
4 treatment in the following areas: (i) self care and
5 feeding, (ii) pragmatic, receptive, and expressive
6 language, (iii) cognitive functioning, (iv) applied
7 behavior analysis, intervention, and modification, (v)
8 motor planning, and (vi) sensory processing.

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

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

18 (215 ILCS 5/356z.40)

19 (Text of Section before amendment by P.A. 103-701 and
20 103-720)

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

22 (a) An individual or group policy of accident and health
23 insurance or managed care plan amended, delivered, issued, or
24 renewed on or after October 8, 2021 (the effective date of
25 Public Act 102-665) ~~this amendatory Act of the 102nd General~~

1 ~~Assembly~~ shall provide coverage for pregnancy and newborn care
2 in accordance with 42 U.S.C. 18022(b) regarding essential
3 health benefits.

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

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

1 pregnancy or childbirth, including, but not limited to,
2 hypertension disorders, gestational diabetes, and
3 hemorrhage.

4 (2) An individual shall have access to medically
5 necessary treatment of a mental, emotional, nervous, or
6 substance use disorder or condition consistent with the
7 requirements set forth in this Section and in Sections
8 370c and 370c.1 of this Code. Prior authorization
9 requirements are prohibited to the extent provided in
10 Section 370c.

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

1 the insurance policy.

2 (4) The benefits for the first 48 hours of initiation
3 of services for an inpatient admission, detoxification or
4 withdrawal management program, or partial hospitalization
5 admission for the treatment of a mental, emotional,
6 nervous, or substance use disorder or condition related to
7 pregnancy or postpartum complications shall be provided
8 without post-service or concurrent review of medical
9 necessity, as the medical necessity for the first 48 hours
10 of such services shall be determined solely by the covered
11 pregnant or postpartum individual's provider. Subject to
12 Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in
13 this paragraph shall prevent an insurer from applying
14 concurrent and post-service utilization review, including
15 the review of medical necessity, case management,
16 experimental and investigational treatments, managed care
17 provisions, and other terms and conditions of the
18 insurance policy, of any inpatient admission,
19 detoxification or withdrawal management program admission,
20 or partial hospitalization admission services for the
21 treatment of a mental, emotional, nervous, or substance
22 use disorder or condition related to pregnancy or
23 postpartum complications received 48 hours after the
24 initiation of such services. If an insurer determines that
25 the services are no longer medically necessary, then the
26 covered person shall have the right to external review

1 pursuant to the requirements of the Health Carrier
2 External Review Act.

3 (5) If an insurer determines that continued inpatient
4 care, detoxification or withdrawal management, partial
5 hospitalization, intensive outpatient treatment, or
6 outpatient treatment in a facility is no longer medically
7 necessary, the insurer shall, within 24 hours, provide
8 written notice to the covered pregnant or postpartum
9 individual and the covered pregnant or postpartum
10 individual's provider of its decision and the right to
11 file an expedited internal appeal of the determination.
12 The insurer shall review and make a determination with
13 respect to the internal appeal within 24 hours and
14 communicate such determination to the covered pregnant or
15 postpartum individual and the covered pregnant or
16 postpartum individual's provider. If the determination is
17 to uphold the denial, the covered pregnant or postpartum
18 individual and the covered pregnant or postpartum
19 individual's provider have the right to file an expedited
20 external appeal. An independent review organization shall
21 make a determination within 72 hours. If the insurer's
22 determination is upheld and it is determined that
23 continued inpatient care, detoxification or withdrawal
24 management, partial hospitalization, intensive outpatient
25 treatment, or outpatient treatment is not medically
26 necessary, or if the insurer's determination is not

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

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

22 (7) The benefits required by paragraphs (2) and (6) of
23 this subsection (b) are to be provided to all covered
24 pregnant or postpartum individuals with a diagnosis of a
25 mental, emotional, nervous, or substance use disorder or
26 condition. The presence of additional related or unrelated

1 diagnoses shall not be a basis to reduce or deny the
2 benefits required by this subsection (b).

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

5 (Text of Section after amendment by P.A. 103-701 and
6 103-720)

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

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

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

17 (1) An individual who has been identified as
18 experiencing a high-risk pregnancy by the individual's
19 treating provider shall have access to clinically
20 appropriate case management programs. As used in this
21 subsection, "case management" means a mechanism to
22 coordinate and assure continuity of services, including,
23 but not limited to, health services, social services, and
24 educational services necessary for the individual. "Case
25 management" involves individualized assessment of needs,

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

17 (2) An individual shall have access to medically
18 necessary treatment of a mental, emotional, nervous, or
19 substance use disorder or condition consistent with the
20 requirements set forth in this Section and in Sections
21 370c and 370c.1 of this Code. Prior authorization
22 requirements are prohibited to the extent provided in
23 Section 370c.

24 (3) The benefits provided for inpatient and outpatient
25 services for the medically necessary treatment of a
26 mental, emotional, nervous, or substance use disorder or

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

15 (4) The benefits for the first 48 hours of initiation
16 of services for an inpatient admission, detoxification or
17 withdrawal management program, or partial hospitalization
18 admission for the treatment of a mental, emotional,
19 nervous, or substance use disorder or condition related to
20 pregnancy or postpartum complications shall be provided
21 without post-service or concurrent review of medical
22 necessity, as the medical necessity for the first 48 hours
23 of such services shall be determined solely by the covered
24 pregnant or postpartum individual's provider. Subject to
25 Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in
26 this paragraph shall prevent an insurer from applying

1 concurrent and post-service utilization review, including
2 the review of medical necessity, case management,
3 experimental and investigational treatments, managed care
4 provisions, and other terms and conditions of the
5 insurance policy, of any inpatient admission,
6 detoxification or withdrawal management program admission,
7 or partial hospitalization admission services for the
8 treatment of a mental, emotional, nervous, or substance
9 use disorder or condition related to pregnancy or
10 postpartum complications received 48 hours after the
11 initiation of such services. If an insurer determines that
12 the services are no longer medically necessary, then the
13 covered person shall have the right to external review
14 pursuant to the requirements of the Health Carrier
15 External Review Act.

16 (5) If an insurer determines that continued inpatient
17 care, detoxification or withdrawal management, partial
18 hospitalization, intensive outpatient treatment, or
19 outpatient treatment in a facility is no longer medically
20 necessary, the insurer shall, within 24 hours, provide
21 written notice to the covered pregnant or postpartum
22 individual and the covered pregnant or postpartum
23 individual's provider of its decision and the right to
24 file an expedited internal appeal of the determination.
25 The insurer shall review and make a determination with
26 respect to the internal appeal within 24 hours and

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

1 appeals and independent utilization review organization
2 appeals are exhausted. A decision to reverse an adverse
3 determination shall comply with the Health Carrier
4 External Review Act.

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

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

18 (8) Insurers shall cover all services for pregnancy,
19 postpartum, and newborn care that are rendered by
20 perinatal doulas or licensed certified professional
21 midwives, including home births, home visits, and support
22 during labor, abortion, or miscarriage. Coverage shall
23 include the necessary equipment and medical supplies for a
24 home birth. For home visits by a perinatal doula, not
25 counting any home birth, the policy may limit coverage to
26 16 visits before and 16 visits after a birth, miscarriage,

1 or abortion, provided that the policy shall not be
2 required to cover more than \$8,000 for doula visits for
3 each pregnancy and subsequent postpartum period. As used
4 in this paragraph (8), "perinatal doula" has the meaning
5 given in subsection (a) of Section 5-18.5 of the Illinois
6 Public Aid Code.

7 (9) Coverage for pregnancy, postpartum, and newborn
8 care shall include home visits by lactation consultants
9 and the purchase of breast pumps and breast pump supplies,
10 including such breast pumps, breast pump supplies,
11 breastfeeding supplies, and feeding aids as recommended by
12 the lactation consultant. As used in this paragraph (9),
13 "lactation consultant" means an International
14 Board-Certified Lactation Consultant, a certified
15 lactation specialist with a certification from Lactation
16 Education Consultants, or a certified lactation counselor
17 as defined in subsection (a) of Section 5-18.10 of the
18 Illinois Public Aid Code.

19 (10) Coverage for postpartum services shall apply for
20 all covered services rendered within the first 12 months
21 after the end of pregnancy, subject to any policy
22 limitation on home visits by a perinatal doula allowed
23 under paragraph (8) of this subsection (b). Nothing in
24 this paragraph (10) shall be construed to require a policy
25 to cover services for an individual who is no longer
26 insured or enrolled under the policy. If an individual

1 becomes insured or enrolled under a new policy, the new
2 policy shall cover the individual consistent with the time
3 period and limitations allowed under this paragraph (10).
4 This paragraph (10) is subject to the requirements of
5 Section 25 of the Managed Care Reform and Patient Rights
6 Act, Section 20 of the Network Adequacy and Transparency
7 Act, and 42 U.S.C. 300gg-113.

8 (c) All coverage described in subsection (b), other than
9 health care services for home births, shall be provided
10 without cost-sharing, except that, for mental health services,
11 the cost-sharing prohibition does not apply to inpatient or
12 residential services, and, for substance use disorder
13 services, the cost-sharing prohibition applies only to levels
14 of treatment below and not including Level 3.1 (Clinically
15 Managed Low-Intensity Residential), as established by the
16 American Society for Addiction Medicine. This subsection does
17 not apply to the extent such coverage would disqualify a
18 high-deductible health plan from eligibility for a health
19 savings account pursuant to Section 223 of the Internal
20 Revenue Code.

21 (Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25;
22 103-701, eff. 1-1-26; 103-720, eff. 1-1-26; revised 11-26-24.)

23 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

24 Sec. 370c. Mental and emotional disorders.

25 (a) (1) On and after January 1, 2022 (the effective date of

1 Public Act 102-579), every insurer that amends, delivers,
2 issues, or renews group accident and health policies providing
3 coverage for hospital or medical treatment or services for
4 illness ~~on an expense-incurred basis~~ shall provide coverage
5 for the medically necessary treatment of mental, emotional,
6 nervous, or substance use disorders or conditions consistent
7 with the parity requirements of Section 370c.1 of this Code.

8 (2) Each insured that is covered for mental, emotional,
9 nervous, or substance use disorders or conditions shall be
10 free to select the physician licensed to practice medicine in
11 all its branches, licensed clinical psychologist, licensed
12 clinical social worker, licensed clinical professional
13 counselor, licensed marriage and family therapist, licensed
14 speech-language pathologist, or other licensed or certified
15 professional at a program licensed pursuant to the Substance
16 Use Disorder Act of his or her choice to treat such disorders,
17 and the insurer shall pay the covered charges of such
18 physician licensed to practice medicine in all its branches,
19 licensed clinical psychologist, licensed clinical social
20 worker, licensed clinical professional counselor, licensed
21 marriage and family therapist, licensed speech-language
22 pathologist, or other licensed or certified professional at a
23 program licensed pursuant to the Substance Use Disorder Act up
24 to the limits of coverage, provided (i) the disorder or
25 condition treated is covered by the policy, and (ii) the
26 physician, licensed psychologist, licensed clinical social

1 worker, licensed clinical professional counselor, licensed
2 marriage and family therapist, licensed speech-language
3 pathologist, or other licensed or certified professional at a
4 program licensed pursuant to the Substance Use Disorder Act is
5 authorized to provide said services under the statutes of this
6 State and in accordance with accepted principles of his or her
7 profession.

8 (3) Insofar as this Section applies solely to licensed
9 clinical social workers, licensed clinical professional
10 counselors, licensed marriage and family therapists, licensed
11 speech-language pathologists, and other licensed or certified
12 professionals at programs licensed pursuant to the Substance
13 Use Disorder Act, those persons who may provide services to
14 individuals shall do so after the licensed clinical social
15 worker, licensed clinical professional counselor, licensed
16 marriage and family therapist, licensed speech-language
17 pathologist, or other licensed or certified professional at a
18 program licensed pursuant to the Substance Use Disorder Act
19 has informed the patient of the desirability of the patient
20 conferring with the patient's primary care physician.

21 (4) "Mental, emotional, nervous, or substance use disorder
22 or condition" means a condition or disorder that involves a
23 mental health condition or substance use disorder that falls
24 under any of the diagnostic categories listed in the mental
25 and behavioral disorders chapter of the current edition of the
26 World Health Organization's International Classification of

1 Disease or that is listed in the most recent version of the
2 American Psychiatric Association's Diagnostic and Statistical
3 Manual of Mental Disorders. "Mental, emotional, nervous, or
4 substance use disorder or condition" includes any mental
5 health condition that occurs during pregnancy or during the
6 postpartum period and includes, but is not limited to,
7 postpartum depression.

8 (5) Medically necessary treatment and medical necessity
9 determinations shall be interpreted and made in a manner that
10 is consistent with and pursuant to subsections (h) through (y)
11 ~~(t)~~.

12 (b) (1) (Blank).

13 (2) (Blank).

14 (2.5) (Blank).

15 (3) Unless otherwise prohibited by federal law and
16 consistent with the parity requirements of Section 370c.1 of
17 this Code, the ~~reimbursing~~ insurer that amends, delivers,
18 issues, or renews a group or individual policy of accident and
19 health insurance, a qualified health plan offered through the
20 health insurance marketplace, or a provider of treatment of
21 mental, emotional, nervous, or substance use disorders or
22 conditions shall furnish medical records or other necessary
23 data that substantiate that initial or continued treatment is
24 at all times medically necessary. Nothing in this paragraph
25 (3) supersedes the prohibition on prior authorization
26 requirements to the extent provided under subsections (g) and

1 (w) and subparagraph (A) of paragraph (6.5) of this
2 subsection. ~~An insurer shall provide a mechanism for the~~
3 ~~timely review by a provider holding the same license and~~
4 ~~practicing in the same specialty as the patient's provider,~~
5 ~~who is unaffiliated with the insurer, jointly selected by the~~
6 ~~patient (or the patient's next of kin or legal representative~~
7 ~~if the patient is unable to act for himself or herself), the~~
8 ~~patient's provider, and the insurer in the event of a dispute~~
9 ~~between the insurer and patient's provider regarding the~~
10 ~~medical necessity of a treatment proposed by a patient's~~
11 ~~provider. If the reviewing provider determines the treatment~~
12 ~~to be medically necessary, the insurer shall provide~~
13 ~~reimbursement for the treatment. Future contractual or~~
14 ~~employment actions by the insurer regarding the patient's~~
15 ~~provider may not be based on the provider's participation in~~
16 ~~this procedure.~~ Nothing prevents the insured from agreeing in
17 writing to continue treatment at his or her expense. When
18 making a determination of the medical necessity for a
19 treatment modality for mental, emotional, nervous, or
20 substance use disorders or conditions, an insurer must make
21 the determination in a manner that is consistent with the
22 manner used to make that determination with respect to other
23 diseases or illnesses covered under the policy, including an
24 appeals process. Medical necessity determinations for
25 substance use disorders shall be made in accordance with
26 appropriate patient placement criteria established by the

1 American Society of Addiction Medicine. No additional criteria
2 may be used to make medical necessity determinations for
3 substance use disorders.

4 (4) A group health benefit plan amended, delivered,
5 issued, or renewed on or after January 1, 2019 (the effective
6 date of Public Act 100-1024) or an individual policy of
7 accident and health insurance or a qualified health plan
8 offered through the health insurance marketplace amended,
9 delivered, issued, or renewed on or after January 1, 2019 (the
10 effective date of Public Act 100-1024):

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

17 (i) 45 days of inpatient treatment; and

18 (ii) beginning on June 26, 2006 (the effective
19 date of Public Act 94-921), 60 visits for outpatient
20 treatment including group and individual outpatient
21 treatment; and

22 (iii) for plans or policies delivered, issued for
23 delivery, renewed, or modified after January 1, 2007
24 (the effective date of Public Act 94-906), 20
25 additional outpatient visits for speech therapy for
26 treatment of pervasive developmental disorders that

1 will be in addition to speech therapy provided
2 pursuant to item (ii) of this subparagraph (A); and

3 (B) may not include a lifetime limit on the number of
4 days of inpatient treatment or the number of outpatient
5 visits covered under the plan.

6 (C) (Blank).

7 (5) An issuer of a group health benefit plan or an
8 individual policy of accident and health insurance or a
9 qualified health plan offered through the health insurance
10 marketplace may not count toward the number of outpatient
11 visits required to be covered under this Section an outpatient
12 visit for the purpose of medication management and shall cover
13 the outpatient visits under the same terms and conditions as
14 it covers outpatient visits for the treatment of physical
15 illness.

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

1 treating provider shall base all treatment recommendations and
2 the health benefit plan shall base all medical necessity
3 determinations for medication-assisted treatment in accordance
4 with the most current Treatment Criteria for Addictive,
5 Substance-Related, and Co-Occurring Conditions established by
6 the American Society of Addiction Medicine.

7 As used in this subsection:

8 "Acute treatment services" means 24-hour medically
9 supervised addiction treatment that provides evaluation and
10 withdrawal management and may include biopsychosocial
11 assessment, individual and group counseling, psychoeducational
12 groups, and discharge planning.

13 "Clinical stabilization services" means 24-hour treatment,
14 usually following acute treatment services for substance
15 abuse, which may include intensive education and counseling
16 regarding the nature of addiction and its consequences,
17 relapse prevention, outreach to families and significant
18 others, and aftercare planning for individuals beginning to
19 engage in recovery from addiction.

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

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

25 (6.5) An individual or group health benefit plan amended,
26 delivered, issued, or renewed on or after January 1, 2019 (the

1 effective date of Public Act 100-1024):

2 (A) shall not impose prior authorization requirements,
3 including limitations on dosage, other than those
4 established under the Treatment Criteria for Addictive,
5 Substance-Related, and Co-Occurring Conditions
6 established by the American Society of Addiction Medicine,
7 on a prescription medication approved by the United States
8 Food and Drug Administration that is prescribed or
9 administered for the treatment of substance use disorders;

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

11 (C) shall place all prescription medications approved
12 by the United States Food and Drug Administration
13 prescribed or administered for the treatment of substance
14 use disorders on, for brand medications, the lowest tier
15 of the drug formulary developed and maintained by the
16 individual or group health benefit plan that covers brand
17 medications and, for generic medications, the lowest tier
18 of the drug formulary developed and maintained by the
19 individual or group health benefit plan that covers
20 generic medications; and

21 (D) shall not exclude coverage for a prescription
22 medication approved by the United States Food and Drug
23 Administration for the treatment of substance use
24 disorders and any associated counseling or wraparound
25 services on the grounds that such medications and services
26 were court ordered.

1 (7) (Blank).

2 (8) (Blank).

3 (9) With respect to all mental, emotional, nervous, or
4 substance use disorders or conditions, coverage for inpatient
5 treatment shall include coverage for treatment in a
6 residential treatment center certified or licensed by the
7 Department of Public Health or the Department of Human
8 Services.

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

12 (d) With respect to a group or individual policy of
13 accident and health insurance or a qualified health plan
14 offered through the health insurance marketplace, the
15 Department and, with respect to medical assistance, the
16 Department of Healthcare and Family Services shall each
17 enforce the requirements of this Section and Sections 356z.23
18 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
19 Mental Health Parity and Addiction Equity Act of 2008, 42
20 U.S.C. 18031(j), and any amendments to, and federal guidance
21 or regulations issued under, those Acts, including, but not
22 limited to, final regulations issued under the Paul Wellstone
23 and Pete Domenici Mental Health Parity and Addiction Equity
24 Act of 2008 and final regulations applying the Paul Wellstone
25 and Pete Domenici Mental Health Parity and Addiction Equity
26 Act of 2008 to Medicaid managed care organizations, the

1 Children's Health Insurance Program, and alternative benefit
2 plans. Specifically, the Department and the Department of
3 Healthcare and Family Services shall take action:

4 (1) proactively ensuring compliance by individual and
5 group policies, including by requiring that insurers
6 submit comparative analyses, as set forth in paragraph (6)
7 of subsection (k) of Section 370c.1, demonstrating how
8 they design and apply nonquantitative treatment
9 limitations, both as written and in operation, for mental,
10 emotional, nervous, or substance use disorder or condition
11 benefits as compared to how they design and apply
12 nonquantitative treatment limitations, as written and in
13 operation, for medical and surgical benefits;

14 (2) evaluating all consumer or provider complaints
15 regarding mental, emotional, nervous, or substance use
16 disorder or condition coverage for possible parity
17 violations;

18 (3) performing parity compliance market conduct
19 examinations or, in the case of the Department of
20 Healthcare and Family Services, parity compliance audits
21 of individual and group plans and policies, including, but
22 not limited to, reviews of:

23 (A) nonquantitative treatment limitations,
24 including, but not limited to, prior authorization
25 requirements, concurrent review, retrospective review,
26 step therapy, network admission standards,

1 reimbursement rates, and geographic restrictions;

2 (B) denials of authorization, payment, and
3 coverage; and

4 (C) other specific criteria as may be determined
5 by the Department.

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

8 The Director may adopt rules to effectuate any provisions
9 of the Paul Wellstone and Pete Domenici Mental Health Parity
10 and Addiction Equity Act of 2008 that relate to the business of
11 insurance.

12 (e) Availability of plan information.

13 (1) The criteria for medical necessity determinations
14 made under a group health plan, an individual policy of
15 accident and health insurance, or a qualified health plan
16 offered through the health insurance marketplace with
17 respect to mental health or substance use disorder
18 benefits (or health insurance coverage offered in
19 connection with the plan with respect to such benefits)
20 must be made available by the plan administrator (or the
21 health insurance issuer offering such coverage) to any
22 current or potential participant, beneficiary, or
23 contracting provider upon request.

24 (2) The reason for any denial under a group health
25 benefit plan, an individual policy of accident and health
26 insurance, or a qualified health plan offered through the

1 health insurance marketplace (or health insurance coverage
2 offered in connection with such plan or policy) of
3 reimbursement or payment for services with respect to
4 mental, emotional, nervous, or substance use disorders or
5 conditions benefits in the case of any participant or
6 beneficiary must be made available within a reasonable
7 time and in a reasonable manner and in readily
8 understandable language by the plan administrator (or the
9 health insurance issuer offering such coverage) to the
10 participant or beneficiary upon request.

11 (f) As used in this Section, "group policy of accident and
12 health insurance" and "group health benefit plan" includes (1)
13 State-regulated employer-sponsored group health insurance
14 plans written in Illinois or which purport to provide coverage
15 for a resident of this State; and (2) State, county,
16 municipal, or school district employee health plans.
17 References to an insurer include all plans described in this
18 subsection.

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

20 "Benefits", with respect to insurers that are not Medicaid
21 managed care organizations, means the benefits provided for
22 treatment services for inpatient and outpatient treatment of
23 substance use disorders or conditions at American Society of
24 Addiction Medicine levels of treatment 2.1 (Intensive
25 Outpatient), 2.5 (High-Intensity Outpatient) ~~(Partial~~
26 ~~Hospitalization)~~, 3.1 (Clinically Managed Low-Intensity

1 Residential), ~~3.3 (Clinically Managed Population Specific~~
2 ~~High-Intensity Residential)~~, 3.5 (Clinically Managed
3 High-Intensity Residential), and 3.7 (Medically Managed
4 Residential ~~Monitored Intensive Inpatient~~) and OMT (Opioid
5 Maintenance Therapy) services.

6 "Benefits", with respect to Medicaid managed care
7 organizations, means the benefits provided for treatment
8 services for inpatient and outpatient treatment of substance
9 use disorders or conditions at American Society of Addiction
10 Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5
11 (High-Intensity Outpatient) ~~(Partial Hospitalization)~~, 3.5
12 (Clinically Managed High-Intensity Residential), and 3.7
13 (Medically Managed Residential ~~Monitored Intensive Inpatient~~)
14 and OMT (Opioid Maintenance Therapy) services.

15 "Substance use disorder treatment provider or facility"
16 means a licensed physician, licensed psychologist, licensed
17 psychiatrist, licensed advanced practice registered nurse, or
18 licensed, certified, or otherwise State-approved facility or
19 provider of substance use disorder treatment.

20 (2) A group health insurance policy, an individual health
21 benefit plan, or qualified health plan that is offered through
22 the health insurance marketplace, small employer group health
23 plan, and large employer group health plan that is amended,
24 delivered, issued, executed, or renewed in this State, or
25 approved for issuance or renewal in this State, on or after
26 January 1, 2019 (the effective date of Public Act 100-1023)

1 shall comply with the requirements of this Section and Section
2 370c.1. The services for the treatment and the ongoing
3 assessment of the patient's progress in treatment shall follow
4 the requirements of 77 Ill. Adm. Code 2060.

5 (3) Prior authorization shall not be utilized for the
6 benefits under this subsection. Except to the extent
7 prohibited by Section 370c.1 with respect to treatment
8 limitations in a benefit classification or subclassification,
9 the insurer may require the ~~The~~ substance use disorder
10 treatment provider or facility ~~to shall~~ notify the insurer of
11 the initiation of treatment. For an insurer that is not a
12 Medicaid managed care organization, the substance use disorder
13 treatment provider or facility may be required to give
14 notification ~~shall occur~~ for the initiation of treatment of
15 the covered person within 2 business days. For Medicaid
16 managed care organizations, the substance use disorder
17 treatment provider or facility may be required to give
18 notification ~~shall occur~~ in accordance with the protocol set
19 forth in the provider agreement for initiation of treatment
20 within 24 hours. If the Medicaid managed care organization is
21 not capable of accepting the notification in accordance with
22 the contractual protocol during the 24-hour period following
23 admission, the substance use disorder treatment provider or
24 facility shall have one additional business day to provide the
25 notification to the appropriate managed care organization.
26 Treatment plans shall be developed in accordance with the

1 requirements and timeframes established in 77 Ill. Adm. Code
2 2060. No such coverage shall be subject to concurrent review
3 prior to the applicable notification deadline. If coverage is
4 denied retrospectively, neither the provider or facility nor
5 the insurer shall bill, and the covered individual shall not
6 be liable, for any treatment under this subsection through the
7 date the adverse determination is issued, other than any
8 copayment, coinsurance, or deductible for the treatment or
9 stay through that date as applicable under the policy.
10 Coverage shall not be retrospectively denied for benefits that
11 were furnished at a participating substance use disorder
12 facility prior to the applicable notification deadline except
13 for the following: If the substance use disorder treatment
14 provider or facility fails to notify the insurer of the
15 initiation of treatment in accordance with these provisions,
16 the insurer may follow its normal prior authorization
17 processes.

18 (A) upon reasonable determination that the benefits
19 were not provided;

20 (B) upon determination that the patient receiving the
21 treatment was not an insured, enrollee, or beneficiary
22 under the policy;

23 (C) upon material misrepresentation by the patient or
24 provider. As used in this subparagraph (C), "material"
25 means a fact or situation that is not merely technical in
26 nature and results or could result in a substantial change

1 in the situation;

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

6 (E) upon determination that a service was not
7 medically necessary consistent with subsections (h)
8 through (n); or

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

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

21 Pursuant to the requirements of the Health Carrier
22 External Review Act, the covered person or the covered
23 person's authorized representative may request an expedited
24 external review. An expedited external review may not occur if
25 the substance use disorder treatment provider or facility
26 determines that continued treatment is no longer medically

1 necessary.

2 If an expedited external review request meets the criteria
3 of the Health Carrier External Review Act, an independent
4 review organization shall make a final determination of
5 medical necessity within 72 hours. If an independent review
6 organization upholds an adverse determination, an insurer
7 shall remain responsible to provide coverage of benefits
8 through the day following the determination of the independent
9 review organization. A decision to reverse an adverse
10 determination shall comply with the Health Carrier External
11 Review Act.

12 (5) The substance use disorder treatment provider or
13 facility shall provide the insurer with 7 business days'
14 advance notice of the planned discharge of the patient from
15 the substance use disorder treatment provider or facility and
16 notice on the day that the patient is discharged from the
17 substance use disorder treatment provider or facility.

18 (6) The benefits required by this subsection shall be
19 provided to all covered persons with a diagnosis of substance
20 use disorder or conditions. The presence of additional related
21 or unrelated diagnoses shall not be a basis to reduce or deny
22 the benefits required by this subsection.

23 (7) Nothing in this subsection shall be construed to
24 require an insurer to provide coverage for any of the benefits
25 in this subsection.

26 (8) Any concurrent or retrospective review permitted by

1 this subsection must be consistent with the utilization review
2 provisions in subsections (h) through (n).

3 (h) As used in this Section:

4 "Generally accepted standards of mental, emotional,
5 nervous, or substance use disorder or condition care" means
6 standards of care and clinical practice that are generally
7 recognized by health care providers practicing in relevant
8 clinical specialties such as psychiatry, psychology, clinical
9 sociology, social work, addiction medicine and counseling, and
10 behavioral health treatment. Valid, evidence-based sources
11 reflecting generally accepted standards of mental, emotional,
12 nervous, or substance use disorder or condition care include
13 peer-reviewed scientific studies and medical literature,
14 recommendations of nonprofit health care provider professional
15 associations and specialty societies, including, but not
16 limited to, patient placement criteria and clinical practice
17 guidelines, recommendations of federal government agencies,
18 and drug labeling approved by the United States Food and Drug
19 Administration.

20 "Medically necessary treatment of mental, emotional,
21 nervous, or substance use disorders or conditions" means a
22 service or product addressing the specific needs of that
23 patient, for the purpose of screening, preventing, diagnosing,
24 managing, or treating an illness, injury, or condition or its
25 symptoms and comorbidities, including minimizing the
26 progression of an illness, injury, or condition or its

1 symptoms and comorbidities in a manner that is all of the
2 following:

3 (1) in accordance with the generally accepted
4 standards of mental, emotional, nervous, or substance use
5 disorder or condition care;

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

8 (3) not primarily for the economic benefit of the
9 insurer, purchaser, or for the convenience of the patient,
10 treating physician, or other health care provider.

11 "Utilization review" means either of the following:

12 (1) prospectively, retrospectively, or concurrently
13 reviewing and approving, modifying, delaying, or denying,
14 based in whole or in part on medical necessity, requests
15 by health care providers, insureds, or their authorized
16 representatives for coverage of health care services
17 before, retrospectively, or concurrently with the
18 provision of health care services to insureds.

19 (2) evaluating the medical necessity, appropriateness,
20 level of care, service intensity, efficacy, or efficiency
21 of health care services, benefits, procedures, or
22 settings, under any circumstances, to determine whether a
23 health care service or benefit subject to a medical
24 necessity coverage requirement in an insurance policy is
25 covered as medically necessary for an insured.

26 "Utilization review criteria" means patient placement

1 criteria or any criteria, standards, protocols, or guidelines
2 used by an insurer to conduct utilization review.

3 (i)(1) Every insurer that amends, delivers, issues, or
4 renews a group or individual policy of accident and health
5 insurance or a qualified health plan offered through the
6 health insurance marketplace in this State and Medicaid
7 managed care organizations providing coverage for hospital or
8 medical treatment on or after January 1, 2023 shall, pursuant
9 to subsections (h) through (s), provide coverage for medically
10 necessary treatment of mental, emotional, nervous, or
11 substance use disorders or conditions.

12 (2) An insurer shall not set a specific limit on the
13 duration of benefits or coverage of medically necessary
14 treatment of mental, emotional, nervous, or substance use
15 disorders or conditions or limit coverage only to alleviation
16 of the insured's current symptoms.

17 (3) All utilization review conducted by the insurer
18 concerning diagnosis, prevention, and treatment of insureds
19 diagnosed with mental, emotional, nervous, or substance use
20 disorders or conditions shall be conducted in accordance with
21 the requirements of subsections (k) through (w).

22 (4) An insurer that authorizes a specific type of
23 treatment by a provider pursuant to this Section shall not
24 rescind or modify the authorization after that provider
25 renders the health care service in good faith and pursuant to
26 this authorization for any reason, including, but not limited

1 to, the insurer's subsequent cancellation or modification of
2 the insured's or policyholder's contract, or the insured's or
3 policyholder's eligibility. Nothing in this Section shall
4 require the insurer to cover a treatment when the
5 authorization was granted based on a material
6 misrepresentation by the insured, the policyholder, or the
7 provider. Nothing in this Section shall require Medicaid
8 managed care organizations to pay for services if the
9 individual was not eligible for Medicaid at the time the
10 service was rendered. Nothing in this Section shall require an
11 insurer to pay for services if the individual was not the
12 insurer's enrollee at the time services were rendered. As used
13 in this paragraph, "material" means a fact or situation that
14 is not merely technical in nature and results in or could
15 result in a substantial change in the situation.

16 (j) An insurer shall not limit benefits or coverage for
17 medically necessary services on the basis that those services
18 should be or could be covered by a public entitlement program,
19 including, but not limited to, special education or an
20 individualized education program, Medicaid, Medicare,
21 Supplemental Security Income, or Social Security Disability
22 Insurance, and shall not include or enforce a contract term
23 that excludes otherwise covered benefits on the basis that
24 those services should be or could be covered by a public
25 entitlement program. Nothing in this subsection shall be
26 construed to require an insurer to cover benefits that have

1 been authorized and provided for a covered person by a public
2 entitlement program. Medicaid managed care organizations are
3 not subject to this subsection.

4 (k) An insurer shall base any medical necessity
5 determination or the utilization review criteria that the
6 insurer, and any entity acting on the insurer's behalf,
7 applies to determine the medical necessity of health care
8 services and benefits for the diagnosis, prevention, and
9 treatment of mental, emotional, nervous, or substance use
10 disorders or conditions on current generally accepted
11 standards of mental, emotional, nervous, or substance use
12 disorder or condition care. All denials and appeals shall be
13 reviewed by a professional with experience or expertise
14 comparable to the provider requesting the authorization.

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

1 review of all covered services and benefits for the diagnosis,
2 prevention, and treatment of substance use disorders an
3 insurer shall use the most recent edition of the patient
4 placement criteria established by the American Society of
5 Addiction Medicine.

6 (m) In conducting utilization review relating to level of
7 care placement, continued stay, transfer, discharge, or any
8 other patient care decisions that are within the scope of the
9 sources specified in subsection (l), an insurer shall not
10 apply different, additional, conflicting, or more restrictive
11 utilization review criteria than the criteria set forth in
12 those sources. For all level of care placement decisions, the
13 insurer shall authorize placement at the level of care
14 consistent with the assessment of the insured using the
15 relevant patient placement criteria as specified in subsection
16 (l). If that level of placement is not available, the insurer
17 shall authorize the next higher level of care. In the event of
18 disagreement, the insurer shall provide full detail of its
19 assessment using the relevant criteria as specified in
20 subsection (l) to the provider of the service and the patient.

21 If an insurer purchases or licenses utilization review
22 criteria pursuant to this subsection, the insurer shall verify
23 and document before use that the criteria were developed in
24 accordance with subsection (k).

25 (n) In conducting utilization review that is outside the
26 scope of the criteria as specified in subsection (l) or

1 relates to the advancements in technology or in the types or
2 levels of care that are not addressed in the most recent
3 versions of the sources specified in subsection (l), an
4 insurer shall conduct utilization review in accordance with
5 subsection (k).

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

8 (p) This Section does not in any way limit early and
9 periodic screening, diagnostic, and treatment benefits as
10 defined under 42 U.S.C. 1396d(r).

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

13 (1) Educate the insurer's staff, including any third
14 parties contracted with the insurer to review claims,
15 conduct utilization reviews, or make medical necessity
16 determinations about the utilization review criteria.

17 (2) Make the educational program available to other
18 stakeholders, including the insurer's participating or
19 contracted providers and potential participants,
20 beneficiaries, or covered lives. The education program
21 must be provided at least once a year, in-person or
22 digitally, or recordings of the education program must be
23 made available to the aforementioned stakeholders.

24 (3) Provide, at no cost, the utilization review
25 criteria and any training material or resources to
26 providers and insured patients upon request. For

1 utilization review criteria not concerning level of care
2 placement, continued stay, transfer, discharge, or other
3 patient care decisions used by the insurer pursuant to
4 subsection (m), the insurer may place the criteria on a
5 secure, password-protected website so long as the access
6 requirements of the website do not unreasonably restrict
7 access to insureds or their providers. No restrictions
8 shall be placed upon the insured's or treating provider's
9 access right to utilization review criteria obtained under
10 this paragraph at any point in time, including before an
11 initial request for authorization.

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

15 (5) Conduct interrater reliability testing to ensure
16 consistency in utilization review decision making that
17 covers how medical necessity decisions are made; this
18 assessment shall cover all aspects of utilization review
19 as defined in subsection (h).

20 (6) Run interrater reliability reports about how the
21 clinical guidelines are used in conjunction with the
22 utilization review process and parity compliance
23 activities.

24 (7) Achieve interrater reliability pass rates of at
25 least 90% and, if this threshold is not met, immediately
26 provide for the remediation of poor interrater reliability

1 and interrater reliability testing for all new staff
2 before they can conduct utilization review without
3 supervision.

4 (8) Maintain documentation of interrater reliability
5 testing and the remediation actions taken for those with
6 pass rates lower than 90% and submit to the Department of
7 Insurance or, in the case of Medicaid managed care
8 organizations, the Department of Healthcare and Family
9 Services the testing results and a summary of remedial
10 actions as part of parity compliance reporting set forth
11 in subsection (k) of Section 370c.1.

12 (r) This Section applies to all health care services and
13 benefits for the diagnosis, prevention, and treatment of
14 mental, emotional, nervous, or substance use disorders or
15 conditions covered by an insurance policy, including
16 prescription drugs.

17 (s) This Section applies to an insurer that amends,
18 delivers, issues, or renews a group or individual policy of
19 accident and health insurance or a qualified health plan
20 offered through the health insurance marketplace in this State
21 providing coverage for hospital or medical treatment and
22 conducts utilization review as defined in this Section,
23 including Medicaid managed care organizations, and any entity
24 or contracting provider that performs utilization review or
25 utilization management functions on an insurer's behalf.

26 (t) If the Director determines that an insurer has

1 violated this Section, the Director may, after appropriate
2 notice and opportunity for hearing, by order, assess a civil
3 penalty between \$1,000 and \$5,000 for each violation. Moneys
4 collected from penalties shall be deposited into the Parity
5 Advancement Fund established in subsection (i) of Section
6 370c.1.

7 (u) An insurer shall not adopt, impose, or enforce terms
8 in its policies or provider agreements, in writing or in
9 operation, that undermine, alter, or conflict with the
10 requirements of this Section.

11 (v) The provisions of this Section are severable. If any
12 provision of this Section or its application is held invalid,
13 that invalidity shall not affect other provisions or
14 applications that can be given effect without the invalid
15 provision or application.

16 (w) Beginning January 1, 2026, coverage for medically
17 necessary treatment of mental, emotional, or nervous disorders
18 or conditions for inpatient mental health treatment at
19 participating hospitals shall comply with the following
20 requirements:

21 (1) ~~No Subject to paragraphs (2) and (3) of this~~
22 ~~subsection, no~~ policy shall require prior authorization
23 for outpatient or partial hospitalization services for
24 treatment of mental, emotional, or nervous disorders or
25 conditions provided by a physician licensed to practice
26 medicine in all branches, a licensed clinical

1 psychologist, a licensed clinical social worker, a
2 licensed clinical professional counselor, a licensed
3 marriage and family therapist, a licensed speech-language
4 pathologist, or any other type of licensed, certified, or
5 legally authorized provider, including trainees working
6 under the supervision of a licensed health care
7 professional listed under this subsection, or facility
8 whose outpatient or partial hospitalization services the
9 policy covers for treatment of mental, emotional, or
10 nervous disorders or conditions. Such coverage may be
11 subject to concurrent and retrospective review consistent
12 with the utilization review provisions in subsections (h)
13 through (n) and Section 370c.1. Nothing in this paragraph
14 (1) supersedes a health maintenance organization's
15 referral requirement for services from nonparticipating
16 providers. An insurer may require providers or facilities
17 to notify the insurer of the initiation of treatment as
18 specified in this subsection, except to the extent
19 prohibited by Section 370c.1 with respect to treatment
20 limitations in a benefit classification or
21 subclassification. No such coverage shall be subject to
22 concurrent review for any services furnished before an
23 applicable notification deadline, subject to the
24 following: ~~admission for such treatment at any~~
25 ~~participating hospital.~~

26 (A) In the case of outpatient treatment, for an

1 insurer that is not a Medicaid managed care
2 organization, the insurer may set a notification
3 deadline of 2 business days after the initiation of
4 the covered person's treatment. A Medicaid managed
5 care organization may set a deadline of 24 hours after
6 the initiation of treatment. If the Medicaid managed
7 care organization is not capable of accepting the
8 notification in accordance with the contractual
9 protocol within the 24-hour period following
10 initiation, the treatment provider or facility shall
11 have one additional business day to provide the
12 notification to the Medicaid managed care
13 organization.

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

1 organization.

2 (2) No policy shall require prior authorization for
3 inpatient treatment at a hospital for mental, emotional,
4 or nervous disorders or conditions at a participating
5 provider. Additionally, no such coverage shall ~~Coverage~~
6 ~~provided under this subsection also shall not~~ be subject
7 to concurrent review for the first 72 hours after
8 admission, provided that the provider ~~hospital~~ must notify
9 the insurer of both the admission and the initial
10 treatment plan within 48 hours of admission. A discharge
11 plan must be fully developed and continuity services
12 prepared to meet the patient's needs and the patient's
13 community preference upon release. ~~Nothing in this~~
14 ~~paragraph supersedes a health maintenance organization's~~
15 ~~referral requirement for services from nonparticipating~~
16 ~~providers upon a patient's discharge from a hospital~~
17 Recommended level of care placements identified in the
18 discharge plan shall comply with generally accepted
19 standards of care, as defined in subsection (h).

20 (A) If the provider satisfies the conditions of
21 paragraph (2), then the insurer shall approve coverage
22 of the recommended level of care, if applicable, upon
23 discharge subject to concurrent review.

24 (B) Nothing in this paragraph supersedes a health
25 maintenance organization's referral requirement for
26 services from nonparticipating providers upon a

1 patient's discharge from a hospital or facility.

2 (C) Concurrent review for such coverage must be
3 consistent with the utilization review provisions in
4 subsections (h) through (n).

5 (D) In this subsection, residential treatment that
6 is not otherwise identified in the discharge plan is
7 not inpatient hospitalization.

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

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

25 (B) upon determination that the patient receiving
26 the treatment was not an insured, enrollee, or

1 beneficiary under the policy;

2 (C) upon material misrepresentation by the patient
3 or health care provider. In this item (C), "material"
4 means a fact or situation that is not merely technical
5 in nature and results or could result in a substantial
6 change in the situation; ~~or~~

7 (D) upon determination that a service was excluded
8 under the terms of coverage. In that case, the
9 limitation to billing for a copayment, coinsurance, or
10 deductible shall not apply;~~;~~

11 (E) for outpatient treatment or partial
12 hospitalization programs only, upon determination that
13 a service was not medically necessary consistent with
14 subsections (h) through (n); or

15 (F) upon determination that the patient did not
16 consent to the treatment and that there was no court
17 order mandating the treatment.

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

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

23 Nothing in this subsection shall be construed to
24 require the medical assistance program to reimburse for
25 services not covered by the medical assistance program as
26 authorized by the Illinois Public Aid Code or the

1 Children's Health Insurance Program Act.

2 (x) Notwithstanding any provision of this Section, nothing
3 shall require the medical assistance program under Article V
4 of the Illinois Public Aid Code or the Children's Health
5 Insurance Program Act to violate any applicable federal laws,
6 regulations, or grant requirements, including requirements for
7 utilization management, or any State or federal consent
8 decrees. Nothing in subsection (g) or ~~subsection~~ (w) shall
9 prevent the Department of Healthcare and Family Services from
10 requiring a health care provider to use specified level of
11 care, admission, continued stay, or discharge criteria,
12 including, but not limited to, those under Section 5-5.23 of
13 the Illinois Public Aid Code, as long as the Department of
14 Healthcare and Family Services, subject to applicable federal
15 laws, regulations, or grant requirements, including
16 requirements for utilization management, does not require a
17 health care provider to seek prior authorization or concurrent
18 review from the Department of Healthcare and Family Services,
19 a Medicaid managed care organization, or a utilization review
20 organization under the circumstances expressly prohibited by
21 subsections (g) and ~~subsection~~ (w). Nothing in this Section
22 prohibits a health plan, including a Medicaid managed care
23 organization, from conducting reviews for medical necessity,
24 clinical appropriateness, safety, fraud, waste, or abuse and
25 reporting suspected fraud, waste, or abuse according to State
26 and federal requirements. Nothing in this Section limits the

1 authority of the Department of Healthcare and Family Services
2 or another State agency, or a Medicaid managed care
3 organization on the State agency's behalf, to (i) implement or
4 require programs, services, screenings, assessments, tools, or
5 reviews to comply with applicable federal law, federal
6 regulation, federal grant requirements, any State or federal
7 consent decrees or court orders, or any applicable case law,
8 such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii)
9 administer or require programs, services, screenings,
10 assessments, tools, or reviews established under State or
11 federal laws, rules, or regulations in compliance with State
12 or federal laws, rules, or regulations, including, but not
13 limited to, the Children's Mental Health Act and the Mental
14 Health and Developmental Disabilities Administrative Act.

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

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

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

1 (215 ILCS 124/10)

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

3 Sec. 10. Network adequacy.

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

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

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

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

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

26 (b) Before issuing, delivering, or renewing a network

1 plan, an issuer must file for review a description of the
2 services to be offered through a network plan. The description
3 shall include all of the following:

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

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

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

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

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

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

24 (B) the ratio of physicians and other providers to
25 beneficiaries, by specialty and including primary care
26 physicians and facility-based physicians when

1 applicable under the contract, necessary to meet the
2 health care needs and service demands of the currently
3 enrolled population;

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

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

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

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

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

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

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

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

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

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

1 benefits, except to the extent provided under federal law
2 for stand-alone dental plans. The Department shall
3 consider establishing ratios for the following physicians
4 or other providers:

5 (A) Primary Care;

6 (B) Pediatrics;

7 (C) Cardiology;

8 (D) Gastroenterology;

9 (E) General Surgery;

10 (F) Neurology;

11 (G) OB/GYN;

12 (H) Oncology/Radiation;

13 (I) Ophthalmology;

14 (J) Urology;

15 (K) Behavioral Health;

16 (L) Allergy/Immunology;

17 (M) Chiropractic;

18 (N) Dermatology;

19 (O) Endocrinology;

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

21 (Q) Infectious Disease;

22 (R) Nephrology;

23 (S) Neurosurgery;

24 (T) Orthopedic Surgery;

25 (U) Physiatry/Rehabilitative;

26 (V) Plastic Surgery;

- 1 (W) Pulmonary;
- 2 (X) Rheumatology;
- 3 (Y) Anesthesiology;
- 4 (Z) Pain Medicine;
- 5 (AA) Pediatric Specialty Services;
- 6 (BB) Outpatient Dialysis; and
- 7 (CC) HIV.

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

12 (3) Notwithstanding any other law or rule, the minimum
13 ratio for each provider type shall be no less than any such
14 ratio 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
17 if the network plan is issued in the large group market or
18 is otherwise not issued through an exchange. Federal
19 standards for stand-alone dental plans shall only apply to
20 such network plans. In the absence of an applicable
21 Department rule, the federal standards shall apply for the
22 time period specified in the federal law, regulation, or
23 guidance. If the Centers for Medicare and Medicaid
24 Services establish standards that are more stringent than
25 the standards in effect under any Department rule, the
26 Department may amend its rules to conform to the more

1 stringent federal standards.

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

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

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

19 Notwithstanding any other law or Department rule, the
20 maximum travel time and distance standards and appointment
21 wait time standards shall be no greater than any such
22 standards established for qualified health plans in
23 Federally-Facilitated Exchanges by federal law or by the
24 federal Centers for Medicare and Medicaid Services, even if
25 the network plan is issued in the large group market or is
26 otherwise not issued through an exchange. Federal standards

1 for stand-alone dental plans shall only apply to such network
2 plans. In the absence of an applicable Department rule, the
3 federal standards shall apply for the time period specified in
4 the federal law, regulation, or guidance. If the Centers for
5 Medicare and Medicaid Services establish standards that are
6 more stringent than the standards in effect under any
7 Department rule, the Department may amend its rules to conform
8 to the more stringent federal standards.

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

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

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

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

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

8 (B) For beneficiaries residing in Illinois counties
9 other than those counties listed in subparagraph (A) of
10 this paragraph, network adequacy standards for timely and
11 proximate access to treatment for mental, emotional,
12 nervous, or substance use disorders or conditions means a
13 beneficiary shall not have to travel longer than 60
14 minutes or 60 miles from the beneficiary's residence to
15 receive outpatient treatment for mental, emotional,
16 nervous, or substance use disorders or conditions.
17 Beneficiaries shall not be required to wait longer than 10
18 business days between requesting an initial appointment
19 and being seen by the facility or provider of mental,
20 emotional, nervous, or substance use disorders or
21 conditions for outpatient treatment or to wait longer than
22 20 business days between requesting a repeat or follow-up
23 appointment and being seen by the facility or provider of
24 mental, emotional, nervous, or substance use disorders or
25 conditions for outpatient treatment; however, subject to
26 the protections of paragraph (3) of this subsection, a

1 network plan shall not be held responsible if the
2 beneficiary or provider voluntarily chooses to schedule an
3 appointment outside of these required time frames.

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

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

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

26 (i) Reimbursement for food and lodging shall be at

1 the prevailing federal per diem rates then in effect,
2 as set by the United States General Services
3 Administration. Reimbursement for travel by vehicle
4 shall be reimbursed at the current Internal Revenue
5 Service mileage standard for miles driven for
6 transportation or travel expenses.

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

19 (iii) An issuer may require a beneficiary to
20 submit a claim for food, travel, or lodging
21 reimbursement within 60 days of the last date of the
22 health care service for which travel was undertaken,
23 and the beneficiary may appeal any denial of
24 reimbursement claims.

25 (iv) An issuer may deny reimbursement for food,
26 lodging, and travel if the provider's site of care is

1 neither within this State nor within 100 miles of the
2 beneficiary's residence unless, after a good faith
3 effort, no provider can be found who is available
4 within those parameters to provide the medically
5 necessary health care service within 10 business days
6 after a request for appointment.

7 (B) Notwithstanding any other provision of this
8 Section to the contrary, subparagraph (A) of this
9 paragraph (3) does not apply to policies issued or
10 delivered in this State that provide medical assistance
11 under the Illinois Public Aid Code or the Children's
12 Health Insurance Program Act.

13 (4) If the federal Centers for Medicare and Medicaid
14 Services establishes or law requires more stringent standards
15 for qualified health plans in the Federally-Facilitated
16 Exchanges, the federal standards shall control for all network
17 plans for the time period specified in the federal law,
18 regulation, or guidance, even if the network plan is issued in
19 the large group market, is issued through a different type of
20 Exchange, or is otherwise not issued through an Exchange.

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

24 (f) The network plan may consider use of other health care
25 service delivery options, such as telemedicine or telehealth,
26 mobile clinics, and centers of excellence, or other ways of

1 delivering care to partially meet the requirements set under
2 this Section.

3 (g) Except for the requirements set forth in subsection
4 (d-5), issuers who are not able to comply with the provider
5 ratios and time and distance or appointment wait time
6 standards established under this Act or federal law may
7 request an exception to these requirements from the
8 Department. The Department may grant an exception in the
9 following circumstances:

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

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

26 (3) other circumstances deemed appropriate by the

1 Department consistent with the requirements of this Act.

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

17 (i) If a network plan is inadequate under this Act with
18 respect to a provider type in a county, and if the network plan
19 does not have an approved exception for that provider type in
20 that county pursuant to subsection (g), an issuer shall cover
21 out-of-network claims for covered health care services
22 received from that provider type within that county at the
23 in-network benefit level and shall retroactively adjudicate
24 and reimburse beneficiaries to achieve that objective if their
25 claims were processed at the out-of-network level contrary to
26 this subsection. Nothing in this subsection shall be construed

1 to supersede Section 356z.3a of the Illinois Insurance Code.

2 (j) If the Director determines that a network is
3 inadequate in any county and no exception has been granted
4 under subsection (g) and the issuer does not have a process in
5 place to comply with subsection (d-5), the Director may
6 prohibit the network plan from being issued or renewed within
7 that county until the Director determines that the network is
8 adequate apart from processes and exceptions described in
9 subsections (d-5) and (g). Nothing in this subsection shall be
10 construed to terminate any beneficiary's health insurance
11 coverage under a network plan before the expiration of the
12 beneficiary's policy period if the Director makes a
13 determination under this subsection after the issuance or
14 renewal of the beneficiary's policy or certificate because of
15 a material change. Policies or certificates issued or renewed
16 in violation of this subsection may subject the issuer to a
17 civil penalty of \$5,000 per policy.

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

23 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
24 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

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

1 Sec. 10. Network adequacy.

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

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

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

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

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

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

26 (1) A geographic map of the area proposed to be served

1 by the plan by county service area and zip code, including
2 marked locations for preferred providers.

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

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

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

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

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

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

26 (C) the travel and distance standards for plan

1 beneficiaries in county service areas; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the protections of paragraph (3) of this subsection, a
2 network plan shall not be held responsible if the
3 beneficiary or provider voluntarily chooses to schedule an
4 appointment outside of these required time frames.

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

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

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

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

23 (i) Reimbursement for food and lodging shall be at
24 the prevailing federal per diem rates then in effect,
25 as set by the United States General Services
26 Administration. Reimbursement for travel by vehicle

1 shall be reimbursed at the current Internal Revenue
2 Service mileage standard for miles driven for
3 transportation or travel expenses.

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

16 (iii) An issuer may require a beneficiary to
17 submit a claim for food, travel, or lodging
18 reimbursement within 60 days of the last date of the
19 health care service for which travel was undertaken,
20 and the beneficiary may appeal any denial of
21 reimbursement claims.

22 (iv) An issuer may deny reimbursement for food,
23 lodging, and travel if the provider's site of care is
24 neither within this State nor within 100 miles of the
25 beneficiary's residence unless, after a good faith
26 effort, no provider can be found who is available

1 within those parameters to provide the medically
2 necessary health care service within 10 business days
3 of a request for appointment.

4 (B) Notwithstanding any other provision of this
5 Section to the contrary, subparagraph (A) of this
6 paragraph (3) does not apply to policies issued or
7 delivered in this State that provide medical assistance
8 under the Illinois Public Aid Code or the Children's
9 Health Insurance Program Act.

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

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

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

24 (1) if no providers or facilities meet the specific
25 time and distance standard in a specific service area and
26 the insurer (i) discloses information on the distance and

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

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

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

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

23 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
24 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

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

1 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 with Section 356z.3a of the Illinois Insurance Code.

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

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

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

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

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

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

26 (d) The network plan shall demonstrate to the Director

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

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

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

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

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

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

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

8 (B) For beneficiaries residing in Illinois counties
9 other than those counties listed in subparagraph (A) of
10 this paragraph, network adequacy standards for timely and
11 proximate access to treatment for mental, emotional,
12 nervous, or substance use disorders or conditions means a
13 beneficiary shall not have to travel longer than 60
14 minutes or 60 miles from the beneficiary's residence to
15 receive outpatient treatment for mental, emotional,
16 nervous, or substance use disorders or conditions.
17 Beneficiaries shall not be required to wait longer than 10
18 business days between requesting an initial appointment
19 and being seen by the facility or provider of mental,
20 emotional, nervous, or substance use disorders or
21 conditions for outpatient treatment or to wait longer than
22 20 business days between requesting a repeat or follow-up
23 appointment and being seen by the facility or provider of
24 mental, emotional, nervous, or substance use disorders or
25 conditions for outpatient treatment; however, subject to
26 the protections of paragraph (3) of this subsection, a

1 network plan shall not be held responsible if the
2 beneficiary or provider voluntarily chooses to schedule an
3 appointment outside of these required time frames.

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

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

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

26 (i) Reimbursement for food and lodging shall be at

1 the prevailing federal per diem rates then in effect,
2 as set by the United States General Services
3 Administration. Reimbursement for travel by vehicle
4 shall be reimbursed at the current Internal Revenue
5 Service mileage standard for miles driven for
6 transportation or travel expenses.

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

19 (iii) An issuer may require a beneficiary to
20 submit a claim for food, travel, or lodging
21 reimbursement within 60 days of the last date of the
22 health care service for which travel was undertaken,
23 and the beneficiary may appeal any denial of
24 reimbursement claims.

25 (iv) An issuer may deny reimbursement for food,
26 lodging, and travel if the provider's site of care is

1 neither within this State nor within 100 miles of the
2 beneficiary's residence unless, after a good faith
3 effort, no provider can be found who is available
4 within those parameters to provide the medically
5 necessary health care service within 10 business days
6 of a request for appointment.

7 (B) Notwithstanding any other provision of this
8 Section to the contrary, subparagraph (A) of this
9 paragraph (3) does not apply to policies issued or
10 delivered in this State that provide medical assistance
11 under the Illinois Public Aid Code or the Children's
12 Health Insurance Program Act.

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), insurers who are not able to comply with the provider
23 ratios and time and distance standards established by the
24 Department may request an exception to these requirements from
25 the Department. The Department may grant an exception in the
26 following circumstances:

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

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

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

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

26 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;

1 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

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

3 Sec. 10. Network adequacy.

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

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

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

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

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

25 (b) Insurers must file for review a description of the

1 services to be offered through a network plan. The description
2 shall include all of the following:

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

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

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

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

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

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

23 (B) the ratio of physicians and other providers to
24 beneficiaries, by specialty and including primary care
25 physicians and facility-based physicians when
26 applicable under the contract, necessary to meet the

1 health care needs and service demands of the currently
2 enrolled population;

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

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

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

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

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

1 beneficiary than if the service had been provided by a
2 preferred provider. This provision shall be consistent
3 with Section 356z.3a of the Illinois Insurance Code.

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

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

12 (1) The ratio of physicians or other providers to plan
13 beneficiaries shall be established annually by the
14 Department in consultation with the Department of Public
15 Health based upon the guidance from the federal Centers
16 for Medicare and Medicaid Services. The Department shall
17 not establish ratios for vision or dental providers who
18 provide services under dental-specific or vision-specific
19 benefits, 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) If the federal Centers for Medicare and Medicaid
5 Services establishes minimum provider ratios for
6 stand-alone dental plans in the type of exchange in use in
7 this State for a given plan year, the Department shall
8 enforce those standards for stand-alone dental plans for
9 that plan year.

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

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

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

26 If the federal Centers for Medicare and Medicaid Services

1 establishes appointment wait-time standards for qualified
2 health plans, including stand-alone dental plans, in the type
3 of exchange in use in this State for a given plan year, the
4 Department shall enforce those standards for the same types of
5 qualified health plans for that plan year. If the federal
6 Centers for Medicare and Medicaid Services establishes time
7 and distance standards for stand-alone dental plans in the
8 type of exchange in use in this State for a given plan year,
9 the Department shall enforce those standards for stand-alone
10 dental plans for that plan year.

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

1 of the Illinois Insurance Code and the federal Paul Wellstone
2 and Pete Domenici Mental Health Parity and Addiction Equity
3 Act of 2008. Notwithstanding the foregoing, the network
4 adequacy standards for timely and proximate access to
5 treatment for mental, emotional, nervous, or substance use
6 disorders or conditions shall, at a minimum, satisfy the
7 following requirements:

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

1 beneficiary or provider voluntarily chooses to schedule an
2 appointment outside of these required time frames.

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

25 (2) For beneficiaries residing in all Illinois counties,
26 network adequacy standards for timely and proximate access to

1 treatment for mental, emotional, nervous, or substance use
2 disorders or conditions means a beneficiary shall not have to
3 travel longer than 60 minutes or 60 miles from the
4 beneficiary's residence to receive inpatient or residential
5 treatment for mental, emotional, nervous, or substance use
6 disorders or conditions.

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

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

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

1 transportation or travel expenses.

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

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

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

1 of a request for appointment.

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

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

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

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

24 (g) Except for the requirements set forth in subsection
25 (d-5), insurers who are not able to comply with the provider
26 ratios, time and distance standards, and appointment wait-time

1 standards established under this Act or federal law may
2 request an exception to these requirements from the
3 Department. The Department may grant an exception in the
4 following circumstances:

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

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

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

23 (h) Insurers are required to report to the Director any
24 material change to an approved network plan within 15 days
25 after the change occurs and any change that would result in
26 failure to meet the requirements of this Act. Upon notice from

1 the insurer, the Director shall reevaluate the network plan's
2 compliance with the network adequacy and transparency
3 standards of this Act.

4 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
5 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

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

7 Sec. 10. Network adequacy.

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

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

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

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

21 An insurer shall not prohibit a preferred provider from
22 discussing any specific or all treatment options with
23 beneficiaries irrespective of the insurer's position on those
24 treatment options or from advocating on behalf of
25 beneficiaries within the utilization review, grievance, or

1 appeals processes established by the insurer in accordance
2 with any rights or remedies available under applicable State
3 or federal law.

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

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

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

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

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

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

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

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

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

9 (D) a description of how the use of telemedicine,
10 telehealth, or mobile care services may be used to
11 partially meet the network adequacy standards, if
12 applicable.

13 (6) A provision ensuring that whenever a beneficiary
14 has made a good faith effort, as evidenced by accessing
15 the provider directory, calling the network plan, and
16 calling the provider, to utilize preferred providers for a
17 covered service and it is determined the insurer does not
18 have the appropriate preferred providers due to
19 insufficient number, type, unreasonable travel distance or
20 delay, or preferred providers refusing to provide a
21 covered service because it is contrary to the conscience
22 of the preferred providers, as protected by the Health
23 Care Right of Conscience Act, the insurer shall give the
24 beneficiary a network exception and shall ensure, directly
25 or indirectly, by terms contained in the payer contract,
26 that the beneficiary will be provided the covered service

1 at no greater cost to the beneficiary than if the service
2 had been provided by a preferred provider. This paragraph
3 (6) does not apply to: (A) a beneficiary who willfully
4 chooses to access a non-preferred provider for health care
5 services available through the panel of preferred
6 providers, or (B) a beneficiary enrolled in a health
7 maintenance organization, except that the health
8 maintenance organization must notify the beneficiary when
9 a referral has been granted as a network exception based
10 on any preferred provider access deficiency described in
11 this paragraph or under the circumstances applicable in
12 paragraph (3) of subsection (d-5). In these circumstances,
13 the contractual requirements for non-preferred provider
14 reimbursements shall apply unless Section 356z.3a of the
15 Illinois Insurance Code requires otherwise. In no event
16 shall a beneficiary who receives care at a participating
17 health care facility be required to search for
18 participating providers under the circumstances described
19 in subsection (b) or (b-5) of Section 356z.3a of the
20 Illinois Insurance Code except under the circumstances
21 described in paragraph (2) of subsection (b-5).

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

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

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

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

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

25 (A) Primary Care;

26 (B) Pediatrics;

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

1 (CC) HIV.

2 (1.5) Beginning January 1, 2026, every insurer shall
3 demonstrate to the Director that each in-network hospital
4 has at least one radiologist, pathologist,
5 anesthesiologist, and emergency room physician as a
6 preferred provider in a network plan. The Department may,
7 by rule, require additional types of hospital-based
8 medical specialists to be included as preferred providers
9 in each in-network hospital in a network plan.

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

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

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

26 The Director shall establish a process for the review of

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

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

1 (A) For beneficiaries residing in the metropolitan
2 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
3 network adequacy standards for timely and proximate access
4 to treatment for mental, emotional, nervous, or substance
5 use disorders or conditions means a beneficiary shall not
6 have to travel longer than 30 minutes or 30 miles from the
7 beneficiary's residence to receive outpatient treatment
8 for mental, emotional, nervous, or substance use disorders
9 or conditions. Beneficiaries shall not be required to wait
10 longer than 10 business days between requesting an initial
11 appointment and being seen by the facility or provider of
12 mental, 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 (B) For beneficiaries residing in Illinois counties
23 other than those counties listed in subparagraph (A) of
24 this paragraph, network adequacy standards for timely and
25 proximate access to treatment for mental, emotional,
26 nervous, or substance use disorders or conditions means a

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

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

26 (3) If there is no in-network facility or provider

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

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

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

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

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

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

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

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

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

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

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

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

24 (2) if patterns of care in the service area do not
25 support the need for the requested number of provider or
26 facility type and the insurer provides data on local

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

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

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

14 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
15 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

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

18 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

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

20 Sec. 5-3. Insurance Code provisions.

21 (a) Health Maintenance Organizations shall be subject to
22 the provisions of Sections 133, 134, 136, 137, 139, 140,
23 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
24 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,

1 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,
2 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
3 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
4 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
5 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
6 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
7 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
8 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
9 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
10 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
11 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
12 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5,
13 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
14 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
15 paragraph (c) of subsection (2) of Section 367, and Articles
16 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
17 XXXIIB of the Illinois Insurance Code.

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

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

24 (2) a corporation organized under the laws of this
25 State; or

26 (3) a corporation organized under the laws of another

1 state, 30% or more of the enrollees of which are residents
2 of this State, except a corporation subject to
3 substantially the same requirements in its state of
4 organization as is a "domestic company" under Article VIII
5 1/2 of the Illinois Insurance Code.

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

9 (1) the Director shall give primary consideration to
10 the continuation of benefits to enrollees and the
11 financial conditions of the acquired Health Maintenance
12 Organization after the merger, consolidation, or other
13 acquisition of control takes effect;

14 (2) (i) the criteria specified in subsection (1) (b) of
15 Section 131.8 of the Illinois Insurance Code shall not
16 apply and (ii) the Director, in making his determination
17 with respect to the merger, consolidation, or other
18 acquisition of control, need not take into account the
19 effect on competition of the merger, consolidation, or
20 other acquisition of control;

21 (3) the Director shall have the power to require the
22 following information:

23 (A) certification by an independent actuary of the
24 adequacy of the reserves of the Health Maintenance
25 Organization sought to be acquired;

26 (B) pro forma financial statements reflecting the

1 combined balance sheets of the acquiring company and
2 the Health Maintenance Organization sought to be
3 acquired as of the end of the preceding year and as of
4 a date 90 days prior to the acquisition, as well as pro
5 forma financial statements reflecting projected
6 combined operation for a period of 2 years;

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

11 (D) such other information as the Director shall
12 require.

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

19 (e) In considering any management contract or service
20 agreement subject to Section 141.1 of the Illinois Insurance
21 Code, the Director (i) shall, in addition to the criteria
22 specified in Section 141.2 of the Illinois Insurance Code,
23 take into account the effect of the management contract or
24 service agreement on the continuation of benefits to enrollees
25 and the financial condition of the health maintenance
26 organization to be managed or serviced, and (ii) need not take

1 into account the effect of the management contract or service
2 agreement on competition.

3 (f) Except for small employer groups as defined in the
4 Small Employer Rating, Renewability and Portability Health
5 Insurance Act and except for medicare supplement policies as
6 defined in Section 363 of the Illinois Insurance Code, a
7 Health Maintenance Organization may by contract agree with a
8 group or other enrollment unit to effect refunds or charge
9 additional premiums under the following terms and conditions:

10 (i) the amount of, and other terms and conditions with
11 respect to, the refund or additional premium are set forth
12 in the group or enrollment unit contract agreed in advance
13 of the period for which a refund is to be paid or
14 additional premium is to be charged (which period shall
15 not be less than one year); and

16 (ii) the amount of the refund or additional premium
17 shall not exceed 20% of the Health Maintenance
18 Organization's profitable or unprofitable experience with
19 respect to the group or other enrollment unit for the
20 period (and, for purposes of a refund or additional
21 premium, the profitable or unprofitable experience shall
22 be calculated taking into account a pro rata share of the
23 Health Maintenance Organization's administrative and
24 marketing expenses, but shall not include any refund to be
25 made or additional premium to be paid pursuant to this
26 subsection (f)). The Health Maintenance Organization and

1 the group or enrollment unit may agree that the profitable
2 or unprofitable experience may be calculated taking into
3 account the refund period and the immediately preceding 2
4 plan years.

5 The Health Maintenance Organization shall include a
6 statement in the evidence of coverage issued to each enrollee
7 describing the possibility of a refund or additional premium,
8 and upon request of any group or enrollment unit, provide to
9 the group or enrollment unit a description of the method used
10 to calculate (1) the Health Maintenance Organization's
11 profitable experience with respect to the group or enrollment
12 unit and the resulting refund to the group or enrollment unit
13 or (2) the Health Maintenance Organization's unprofitable
14 experience with respect to the group or enrollment unit and
15 the resulting additional premium to be paid by the group or
16 enrollment unit.

17 In no event shall the Illinois Health Maintenance
18 Organization Guaranty Association be liable to pay any
19 contractual obligation of an insolvent organization to pay any
20 refund authorized under this Section.

21 (g) Rulemaking authority to implement Public Act 95-1045,
22 if any, is conditioned on the rules being adopted in
23 accordance with all provisions of the Illinois Administrative
24 Procedure Act and all rules and procedures of the Joint
25 Committee on Administrative Rules; any purported rule not so
26 adopted, for whatever reason, is unauthorized.

1 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
2 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
3 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
4 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
5 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
6 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
7 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
8 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
9 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
10 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
11 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
12 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
13 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
14 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.
15 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

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

17 Sec. 5-3. Insurance Code provisions.

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

1 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
2 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
3 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
4 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
5 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
6 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
7 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
8 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5,
9 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
10 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
11 paragraph (c) of subsection (2) of Section 367, and Articles
12 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
13 XXXIIB of the Illinois Insurance Code.

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

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

20 (2) a corporation organized under the laws of this
21 State; or

22 (3) a corporation organized under the laws of another
23 state, 30% or more of the enrollees of which are residents
24 of this State, except a corporation subject to
25 substantially the same requirements in its state of
26 organization as is a "domestic company" under Article VIII

1 1/2 of the Illinois Insurance Code.

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

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

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

17 (3) the Director shall have the power to require the
18 following information:

19 (A) certification by an independent actuary of the
20 adequacy of the reserves of the Health Maintenance
21 Organization sought to be acquired;

22 (B) pro forma financial statements reflecting the
23 combined balance sheets of the acquiring company and
24 the Health Maintenance Organization sought to be
25 acquired as of the end of the preceding year and as of
26 a date 90 days prior to the acquisition, as well as pro

1 forma financial statements reflecting projected
2 combined operation for a period of 2 years;

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

7 (D) such other information as the Director shall
8 require.

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

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

25 (f) Except for small employer groups as defined in the
26 Small Employer Rating, Renewability and Portability Health

1 Insurance Act and except for medicare supplement policies as
2 defined in Section 363 of the Illinois Insurance Code, a
3 Health Maintenance Organization may by contract agree with a
4 group or other enrollment unit to effect refunds or charge
5 additional premiums under the following terms and conditions:

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

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

1 The Health Maintenance Organization shall include a
2 statement in the evidence of coverage issued to each enrollee
3 describing the possibility of a refund or additional premium,
4 and upon request of any group or enrollment unit, provide to
5 the group or enrollment unit a description of the method used
6 to calculate (1) the Health Maintenance Organization's
7 profitable experience with respect to the group or enrollment
8 unit and the resulting refund to the group or enrollment unit
9 or (2) the Health Maintenance Organization's unprofitable
10 experience with respect to the group or enrollment unit and
11 the resulting additional premium to be paid by the group or
12 enrollment unit.

13 In no event shall the Illinois Health Maintenance
14 Organization Guaranty Association be liable to pay any
15 contractual obligation of an insolvent organization to pay any
16 refund authorized under this Section.

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

23 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
24 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
25 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
26 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;

1 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
2 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
3 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
4 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
5 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
6 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
7 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
8 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
9 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
10 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.
11 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
12 11-26-24.)

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

15 (215 ILCS 165/10) (from Ch. 32, par. 604)

16 Sec. 10. Application of Insurance Code provisions. Health
17 services plan corporations and all persons interested therein
18 or dealing therewith shall be subject to the provisions of
19 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
20 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3,
21 355.7, 355b, 355d, 356g, 356g.5, 356g.5-1, 356m, 356q, 356r,
22 356t, 356u, 356u.10, 356v, 356w, 356x, 356y, 356z.1, 356z.2,
23 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
24 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18,

1 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
2 356z.32, 356z.32a, 356z.33, 356z.40, 356z.41, 356z.46,
3 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59,
4 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.71,
5 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408,
6 408.2, and 412, and paragraphs (7) and (15) of Section 367 of
7 the Illinois Insurance Code.

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

14 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
15 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff.
16 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,
17 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;
18 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff.
19 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
20 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
21 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-656, eff.
22 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753,
23 eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25;
24 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff.
25 1-1-25; revised 11-26-24.)

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

3 (305 ILCS 5/5-5.28 new)

4 Sec. 5-5.28. Rulemaking authority. The Department of
5 Healthcare and Family Services may adopt rules to implement
6 the applicable provisions of this amendatory Act of the 104th
7 General Assembly to managed care organizations, managed care
8 community networks, and, at the Department's discretion, any
9 other managed care entity described in subsection (i) of
10 Section 5-30 of the Illinois Public Aid Code and the medical
11 assistance fee-for-service program.

12 Section 95. No acceleration or delay. Where this Act makes
13 changes in a statute that is represented in this Act by text
14 that is not yet or no longer in effect (for example, a Section
15 represented by multiple versions), the use of that text does
16 not accelerate or delay the taking effect of (i) the changes
17 made by this Act or (ii) provisions derived from any other
18 Public Act.

19 Section 99. Effective date. This Act takes effect January
20 1, 2026."