



Rep. Lindsey LaPointe

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10400HB3707ham001

LRB104 11351 BAB 23035 a

1 AMENDMENT TO HOUSE BILL 3707

2 AMENDMENT NO. _____. Amend House Bill 3707 by replacing
3 everything after the enacting clause with the following:

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

7 (215 ILCS 5/355.7 new)

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

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

1 and payments of reinsurance, that such coverage expends:

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

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

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

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

16 (c) A health insurance issuer offering group or individual
17 health insurance coverage, including a grandfathered health
18 plan, shall, with respect to each plan year, provide an annual
19 rebate to each enrollee under the coverage on a pro rata basis
20 if, for each of the previous 3 plan years, the ratio of the
21 average amount of premium revenue expended by the issuer on
22 costs described in paragraphs (1) and (2) of subsection (a) to
23 the average total amount of premium revenue, excluding federal
24 and State taxes and licensing or regulatory fees and after
25 accounting for payments or receipts for risk adjustment, risk
26 corridors, and reinsurance under 42 U.S.C. 18061, 18062, and

1 18063 is less than 87% in the individual, small group, or large
2 group market.

3 (d) The rebate in subsection (c) shall be calculated in
4 compliance with 42 U.S.C. 300gg-18 and the federal regulations
5 promulgated thereunder.

6 (e) If 42 U.S.C. 300gg-18 or the federal regulations
7 promulgated thereunder are amended after January 15, 2025 to
8 repeal the reporting or rebate requirements, reduce the amount
9 or types of information required to be reported, or adopt a
10 calculation method that reduces the amount of rebates in this
11 State despite the minimum ratio in this Section remaining 87%,
12 a health insurance issuer shall file a supplemental report
13 with the Director or make supplemental rebate payments, as
14 applicable, for group or individual health insurance coverage
15 regulated by this State to ensure that the same total
16 information is filed with the Director and the same total
17 rebates are remitted to enrollees as before the federal
18 repeal, reduction, or recalculation took effect.

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

22 (1) executive compensation beyond base salary;

23 (2) entity surplus or accumulated profit; or

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

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

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

8 (215 ILCS 5/356z.14)

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

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

19 (b) Coverage provided under this Section shall be subject
20 to a maximum benefit of \$36,000 per year, but shall not be
21 subject to any limits on the number of visits to a service
22 provider. ~~The After December 30, 2009, the~~ Director of ~~the~~
23 ~~Division of~~ Insurance shall, on an annual basis, adjust the
24 maximum benefit for inflation using the Medical Care Component
25 of the United States Department of Labor Consumer Price Index

1 for All Urban Consumers. Payments made by an insurer on behalf
2 of a covered individual for any care, treatment, intervention,
3 service, or item, the provision of which was for the treatment
4 of a health condition not diagnosed as an autism spectrum
5 disorder, shall not be applied toward any maximum benefit
6 established under this subsection.

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

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

21 (e) An insurer may not deny or refuse to provide otherwise
22 covered services, or refuse to renew, refuse to reissue, or
23 otherwise terminate or restrict coverage under an individual
24 contract to provide services to an individual because the
25 individual or the individual's ~~their~~ dependent is diagnosed
26 with an autism spectrum disorder or due to the individual

1 utilizing benefits in this Section.

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

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

21 (g) When making a determination of medical necessity for a
22 treatment modality for autism spectrum disorders, an insurer
23 must make the determination in a manner that is consistent
24 with the manner used to make that determination with respect
25 to other diseases or illnesses covered under the policy,
26 including an appeals process. During the appeals process, any

1 challenge to medical necessity must be viewed as reasonable
2 only if the review includes a physician with expertise in the
3 most current and effective treatment modalities for autism
4 spectrum disorders.

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

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

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

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

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

24 (i) As used in this Section:

25 "Autism spectrum disorders" means pervasive developmental
26 disorders as defined in the most recent edition of the

1 Diagnostic and Statistical Manual of Mental Disorders,
2 including autism, Asperger's disorder, and pervasive
3 developmental disorder not otherwise specified.

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

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

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

1 medicine in all its branches:

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

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

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

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

25 (j) Rulemaking authority to implement this amendatory Act
26 of the 95th General Assembly, if any, is conditioned on the

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

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

8 (215 ILCS 5/356z.40)

9 (Text of Section before amendment by P.A. 103-701 and
10 103-720)

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

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

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

20 (1) An individual who has been identified as
21 experiencing a high-risk pregnancy by the individual's
22 treating provider shall have access to clinically
23 appropriate case management programs. As used in this
24 subsection, "case management" means a mechanism to
25 coordinate and assure continuity of services, including,

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

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

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

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

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

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

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

1 from the inpatient facility, detoxification or withdrawal
2 management, partial hospitalization, intensive outpatient
3 treatment, or outpatient treatment until all internal
4 appeals and independent utilization review organization
5 appeals are exhausted. A decision to reverse an adverse
6 determination shall comply with the Health Carrier
7 External Review Act.

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

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

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

21 (Text of Section after amendment by P.A. 103-701 and
22 103-720)

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

24 (a) An individual or group policy of accident and health
25 insurance or managed care plan amended, delivered, issued, or

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

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

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

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

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

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

1 care services, including review of medical necessity, case
2 management, experimental and investigational treatments,
3 managed care provisions, and other terms and conditions of
4 the insurance policy.

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

1 initiation of such services. If an insurer determines that
2 the services are no longer medically necessary, then the
3 covered person shall have the right to external review
4 pursuant to the requirements of the Health Carrier
5 External Review Act.

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

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

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

25 (7) The benefits required by paragraphs (2) and (6) of
26 this subsection (b) are to be provided to (i) all covered

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

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

23 (9) Coverage for pregnancy, postpartum, and newborn
24 care shall include home visits by lactation consultants
25 and the purchase of breast pumps and breast pump supplies,
26 including such breast pumps, breast pump supplies,

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

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

24 (c) All coverage described in subsection (b), other than
25 health care services for home births, shall be provided
26 without cost-sharing, except that, for mental health services,

1 the cost-sharing prohibition does not apply to inpatient or
2 residential services, and, for substance use disorder
3 services, the cost-sharing prohibition applies only to levels
4 of treatment below and not including Level 3.1 (Clinically
5 Managed Low-Intensity Residential), as established by the
6 American Society for Addiction Medicine. This subsection does
7 not apply to the extent such coverage would disqualify a
8 high-deductible health plan from eligibility for a health
9 savings account pursuant to Section 223 of the Internal
10 Revenue Code.

11 (Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25;
12 103-701, eff. 1-1-26; 103-720, eff. 1-1-26; revised 11-26-24.)

13 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

14 Sec. 370c. Mental and emotional disorders.

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

23 (2) Each insured that is covered for mental, emotional,
24 nervous, or substance use disorders or conditions shall be
25 free to select the physician licensed to practice medicine in

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

24 (3) Insofar as this Section applies solely to licensed
25 clinical social workers, licensed clinical professional
26 counselors, licensed marriage and family therapists, licensed

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

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

24 (5) Medically necessary treatment and medical necessity
25 determinations shall be interpreted and made in a manner that
26 is consistent with and pursuant to subsections (h) through (y)

1 ~~(t)~~.

2 (b) (1) (Blank).

3 (2) (Blank).

4 (2.5) (Blank).

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

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

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

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

7 (i) 45 days of inpatient treatment; and

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

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

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

22 (C) (Blank).

23 (5) An issuer of a group health benefit plan or an
24 individual policy of accident and health insurance or a
25 qualified health plan offered through the health insurance
26 marketplace may not count toward the number of outpatient

1 visits required to be covered under this Section an outpatient
2 visit for the purpose of medication management and shall cover
3 the outpatient visits under the same terms and conditions as
4 it covers outpatient visits for the treatment of physical
5 illness.

6 (5.5) An individual or group health benefit plan amended,
7 delivered, issued, or renewed on or after September 9, 2015
8 (the effective date of Public Act 99-480) shall offer coverage
9 for medically necessary acute treatment services and medically
10 necessary clinical stabilization services. The treating
11 provider shall base all treatment recommendations and the
12 health benefit plan shall base all medical necessity
13 determinations for substance use disorders in accordance with
14 the most current edition of the Treatment Criteria for
15 Addictive, Substance-Related, and Co-Occurring Conditions
16 established by the American Society of Addiction Medicine. The
17 treating provider shall base all treatment recommendations and
18 the health benefit plan shall base all medical necessity
19 determinations for medication-assisted treatment in accordance
20 with the most current Treatment Criteria for Addictive,
21 Substance-Related, and Co-Occurring Conditions established by
22 the American Society of Addiction Medicine.

23 As used in this subsection:

24 "Acute treatment services" means 24-hour medically
25 supervised addiction treatment that provides evaluation and
26 withdrawal management and may include biopsychosocial

1 assessment, individual and group counseling, psychoeducational
2 groups, and discharge planning.

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

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

13 (6.5) An individual or group health benefit plan amended,
14 delivered, issued, or renewed on or after January 1, 2019 (the
15 effective date of Public Act 100-1024):

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

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

25 (C) shall place all prescription medications approved
26 by the United States Food and Drug Administration

1 prescribed or administered for the treatment of substance
2 use disorders on, for brand medications, the lowest tier
3 of the drug formulary developed and maintained by the
4 individual or group health benefit plan that covers brand
5 medications and, for generic medications, the lowest tier
6 of the drug formulary developed and maintained by the
7 individual or group health benefit plan that covers
8 generic medications; and

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

15 (7) (Blank).

16 (8) (Blank).

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

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

26 (d) With respect to a group or individual policy of

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

18 (1) proactively ensuring compliance by individual and
19 group policies, including by requiring that insurers
20 submit comparative analyses, as set forth in paragraph (6)
21 of subsection (k) of Section 370c.1, demonstrating how
22 they design and apply nonquantitative treatment
23 limitations, both as written and in operation, for mental,
24 emotional, nervous, or substance use disorder or condition
25 benefits as compared to how they design and apply
26 nonquantitative treatment limitations, as written and in

1 operation, for medical and surgical benefits;

2 (2) evaluating all consumer or provider complaints
3 regarding mental, emotional, nervous, or substance use
4 disorder or condition coverage for possible parity
5 violations;

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

11 (A) nonquantitative treatment limitations,
12 including, but not limited to, prior authorization
13 requirements, concurrent review, retrospective review,
14 step therapy, network admission standards,
15 reimbursement rates, and geographic restrictions;

16 (B) denials of authorization, payment, and
17 coverage; and

18 (C) other specific criteria as may be determined
19 by the Department.

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

22 The Director may adopt rules to effectuate any provisions
23 of the Paul Wellstone and Pete Domenici Mental Health Parity
24 and Addiction Equity Act of 2008 that relate to the business of
25 insurance.

26 (e) Availability of plan information.

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

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

25 (f) As used in this Section, "group policy of accident and
26 health insurance" and "group health benefit plan" includes (1)

1 State-regulated employer-sponsored group health insurance
2 plans written in Illinois or which purport to provide coverage
3 for a resident of this State; and (2) State employee health
4 plans.

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

6 "Benefits", with respect to insurers, means the benefits
7 provided for treatment services for inpatient and outpatient
8 treatment of substance use disorders or conditions at American
9 Society of Addiction Medicine levels of treatment 2.1
10 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1
11 (Clinically Managed Low-Intensity Residential), 3.3
12 (Clinically Managed Population-Specific High-Intensity
13 Residential), 3.5 (Clinically Managed High-Intensity
14 Residential), and 3.7 (Medically Monitored Intensive
15 Inpatient) and OMT (Opioid Maintenance Therapy) services.

16 "Benefits", with respect to managed care organizations,
17 means the benefits provided for treatment services for
18 inpatient and outpatient treatment of substance use disorders
19 or conditions at American Society of Addiction Medicine levels
20 of treatment 2.1 (Intensive Outpatient), 2.5 (Partial
21 Hospitalization), 3.5 (Clinically Managed High-Intensity
22 Residential), and 3.7 (Medically Monitored Intensive
23 Inpatient) and OMT (Opioid Maintenance Therapy) services.

24 "Substance use disorder treatment provider or facility"
25 means a licensed physician, licensed psychologist, licensed
26 psychiatrist, licensed advanced practice registered nurse, or

1 licensed, certified, or otherwise State-approved facility or
2 provider of substance use disorder treatment.

3 (2) A group health insurance policy, an individual health
4 benefit plan, or qualified health plan that is offered through
5 the health insurance marketplace, small employer group health
6 plan, and large employer group health plan that is amended,
7 delivered, issued, executed, or renewed in this State, or
8 approved for issuance or renewal in this State, on or after
9 January 1, 2019 (the effective date of Public Act 100-1023)
10 shall comply with the requirements of this Section and Section
11 370c.1. The services for the treatment and the ongoing
12 assessment of the patient's progress in treatment shall follow
13 the requirements of 77 Ill. Adm. Code 2060.

14 (3) Prior authorization shall not be utilized for the
15 benefits under this subsection. The substance use disorder
16 treatment provider or facility shall notify the insurer of the
17 initiation of treatment. For an insurer that is not a managed
18 care organization, the substance use disorder treatment
19 provider or facility notification shall occur for the
20 initiation of treatment of the covered person within 2
21 business days. For managed care organizations, the substance
22 use disorder treatment provider or facility notification shall
23 occur in accordance with the protocol set forth in the
24 provider agreement for initiation of treatment within 24
25 hours. If the managed care organization is not capable of
26 accepting the notification in accordance with the contractual

1 protocol during the 24-hour period following admission, the
2 substance use disorder treatment provider or facility shall
3 have one additional business day to provide the notification
4 to the appropriate managed care organization. Treatment plans
5 shall be developed in accordance with the requirements and
6 timeframes established in 77 Ill. Adm. Code 2060. Coverage
7 shall not be retrospectively denied for benefits that were
8 furnished at a participating substance use disorder facility
9 prior to the applicable notification deadline except for the
10 following: ~~If the substance use disorder treatment provider or~~
11 ~~facility fails to notify the insurer of the initiation of~~
12 ~~treatment in accordance with these provisions, the insurer may~~
13 ~~follow its normal prior authorization processes.~~

14 (A) upon reasonable determination that the benefits
15 were not provided;

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

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

24 (D) upon determination that a service was excluded
25 under the terms of coverage. For situations that qualify
26 under this subparagraph (D), the limitation to billing for

1 a copayment, coinsurance, or deductible shall not apply;

2 or

3 (E) upon determination that the patient did not
4 consent to the treatment and that there was no court order
5 mandating the treatment.

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

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

22 If an expedited external review request meets the criteria
23 of the Health Carrier External Review Act, an independent
24 review organization shall make a final determination of
25 medical necessity within 72 hours. If an independent review
26 organization upholds an adverse determination, an insurer

1 shall remain responsible to provide coverage of benefits
2 through the day following the determination of the independent
3 review organization. A decision to reverse an adverse
4 determination shall comply with the Health Carrier External
5 Review Act.

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

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

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

20 (h) As used in this Section:

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

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

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

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

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

25 (3) not primarily for the economic benefit of the
26 insurer, purchaser, or for the convenience of the patient,

1 treating physician, or other health care provider.

2 "Utilization review" means either of the following:

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

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

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

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

1 necessary treatment of mental, emotional, nervous, or
2 substance use disorders or conditions.

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

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

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

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

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

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

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

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

23 (m) In conducting utilization review relating to level of
24 care placement, continued stay, transfer, discharge, or any
25 other patient care decisions that are within the scope of the
26 sources specified in subsection (l), an insurer shall not

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

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

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

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

25 (p) This Section does not in any way limit early and
26 periodic screening, diagnostic, and treatment benefits as

1 defined under 42 U.S.C. 1396d(r).

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

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

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

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

1 this paragraph at any point in time, including before an
2 initial request for authorization.

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

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

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

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

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

1 actions as part of parity compliance reporting set forth
2 in subsection (k) of Section 370c.1.

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

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

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

24 (u) An insurer shall not adopt, impose, or enforce terms
25 in its policies or provider agreements, in writing or in
26 operation, that undermine, alter, or conflict with the

1 requirements of this Section.

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

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

11 (1) ~~No~~ Subject to paragraphs (2) and (3) of this
12 ~~subsection, no~~ policy shall require prior authorization
13 for outpatient treatment of mental, emotional, or nervous
14 disorders or conditions provided by a physician licensed
15 to practice medicine in all branches, a licensed clinical
16 psychologist, a licensed clinical social worker, a
17 licensed clinical professional counselor, a licensed
18 marriage and family therapist, or a licensed
19 speech-language pathologist. Such coverage may be subject
20 to concurrent and retrospective review consistent with the
21 utilization review provisions in subsections (h) through
22 (n). Nothing in this paragraph (1) supersedes a health
23 maintenance organization's referral requirement for
24 services from nonparticipating providers. ~~admission for~~
25 ~~such treatment at any participating hospital.~~

26 (2) No policy shall require prior authorization for

1 admission to inpatient treatment at a hospital, including
2 inpatient hospitalization or partial hospitalization, for
3 mental, emotional, or nervous disorders or conditions at a
4 participating provider. Additionally, no such coverage
5 shall ~~Coverage provided under this subsection also shall~~
6 ~~not~~ be subject to concurrent review for the first 72 hours
7 after admission, provided that the provider ~~hospital~~ must
8 notify the insurer of both the admission and the initial
9 treatment plan within 48 hours of admission. A discharge
10 plan must be fully developed and continuity services
11 prepared to meet the patient's needs and the patient's
12 community preference upon release. Nothing in this
13 paragraph supersedes a health maintenance organization's
14 referral requirement for services from nonparticipating
15 providers upon a patient's discharge from a hospital or
16 facility. Concurrent review for such coverage must be
17 consistent with the utilization review provisions in
18 subsections (h) through (n).

19 (3) Coverage for admission to inpatient
20 hospitalization for treatment of mental, emotional, or
21 nervous disorders or conditions may be reviewed
22 retrospectively consistent with the utilization review
23 provisions in subsections (g) through (n). If such
24 coverage ~~Treatment provided under this subsection may be~~
25 ~~reviewed retrospectively. If coverage is denied~~
26 ~~retrospectively, neither the insurer nor the participating~~

1 provider hospital shall bill, and the insured shall not be
2 liable, for any treatment under this subsection through
3 the date the adverse determination is issued, other than
4 any copayment, coinsurance, or deductible for the stay
5 through that date as applicable under the policy. Coverage
6 shall not be retrospectively denied for the first 72 hours
7 of admission to inpatient hospitalization for treatment of
8 mental, emotional, or nervous disorders or conditions
9 ~~treatment~~ at a participating provider hospital except:

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

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

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

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

24 (E) upon determination that the patient did not
25 consent to the treatment and that there was no court
26 order mandating the treatment.

1 (4) Nothing in this subsection shall be construed to
2 require a policy to cover any health care service excluded
3 under the terms of coverage.

4 (5) This subsection does not apply to coverage for any
5 prescription drug.

6 (6) Nothing in this subsection shall be construed to
7 require the medical assistance program to reimburse for
8 services not covered by the medical assistance program as
9 authorized by the Illinois Public Aid Code or the
10 Children's Health Insurance Program Act.

11 (x) Notwithstanding any provision of this Section, nothing
12 shall require the medical assistance program under Article V
13 of the Illinois Public Aid Code or the Children's Health
14 Insurance Program Act to violate any applicable federal laws,
15 regulations, or grant requirements, including requirements for
16 utilization management, or any State or federal consent
17 decrees. Nothing in subsection (g) or ~~subsection~~ (w) shall
18 prevent the Department of Healthcare and Family Services from
19 requiring a health care provider to use specified level of
20 care, admission, continued stay, or discharge criteria,
21 including, but not limited to, those under Section 5-5.23 of
22 the Illinois Public Aid Code, as long as the Department of
23 Healthcare and Family Services, subject to applicable federal
24 laws, regulations, or grant requirements, including
25 requirements for utilization management, does not require a
26 health care provider to seek prior authorization or concurrent

1 review from the Department of Healthcare and Family Services,
2 a Medicaid managed care organization, or a utilization review
3 organization under the circumstances expressly prohibited by
4 subsections (g) and subsection (w). Nothing in this Section
5 prohibits a health plan, including a Medicaid managed care
6 organization, from conducting reviews for medical necessity,
7 clinical appropriateness, safety, fraud, waste, or abuse and
8 reporting suspected fraud, waste, or abuse according to State
9 and federal requirements. Nothing in this Section limits the
10 authority of the Department of Healthcare and Family Services
11 or another State agency, or a Medicaid managed care
12 organization on the State agency's behalf, to (i) implement or
13 require programs, services, screenings, assessments, tools, or
14 reviews to comply with applicable federal law, federal
15 regulation, federal grant requirements, any State or federal
16 consent decrees or court orders, or any applicable case law,
17 such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii)
18 administer or require programs, services, screenings,
19 assessments, tools, or reviews established under State or
20 federal laws, rules, or regulations in compliance with State
21 or federal laws, rules, or regulations, including, but not
22 limited to, the Children's Mental Health Act and the Mental
23 Health and Developmental Disabilities Administrative Act.

24 (y) (Blank). ~~Children's Mental Health. Nothing in this~~
25 ~~Section shall suspend the screening and assessment~~
26 ~~requirements for mental health services for children~~

1 ~~participating in the State's medical assistance program as~~
2 ~~required in Section 5-5.23 of the Illinois Public Aid Code.~~

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

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

8 (215 ILCS 124/10)

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

10 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 covered service because it is contrary to the conscience
2 of the preferred providers, as protected by the Health
3 Care Right of Conscience Act, the issuer shall ensure,
4 directly or indirectly, by terms contained in the payer
5 contract, that the beneficiary will be provided the
6 covered service at no greater cost to the beneficiary than
7 if the service had been provided by a preferred provider.
8 This paragraph (6) does not apply to: (A) a beneficiary
9 who willfully chooses to access a non-preferred provider
10 for health care services available through the panel of
11 preferred providers, or (B) a beneficiary enrolled in a
12 health maintenance organization. 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 (9) For a network plan to be offered through the
14 Exchange in the individual or small group market, as well
15 as any off-Exchange mirror of such a network plan,
16 evidence that the network plan includes essential
17 community providers in accordance with rules established
18 by the Exchange that will operate in this State for the
19 applicable plan year.

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

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

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

8 (A) Primary Care;

9 (B) Pediatrics;

10 (C) Cardiology;

11 (D) Gastroenterology;

12 (E) General Surgery;

13 (F) Neurology;

14 (G) OB/GYN;

15 (H) Oncology/Radiation;

16 (I) Ophthalmology;

17 (J) Urology;

18 (K) Behavioral Health;

19 (L) Allergy/Immunology;

20 (M) Chiropractic;

21 (N) Dermatology;

22 (O) Endocrinology;

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

24 (Q) Infectious Disease;

25 (R) Nephrology;

26 (S) Neurosurgery;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (A) For plan or policy years beginning on or after
25 January 1, 2026, the issuer also shall provide reasonable
26 reimbursement to a beneficiary for costs including food,

1 lodging, and travel. Reimbursement for food and lodging
2 shall be at the prevailing federal per diem rates, then in
3 effect, as set by the United States General Services
4 Administration. Reimbursement for travel by vehicle shall
5 be reimbursed at the current Internal Revenue Service
6 mileage standard for miles driven for transportation or
7 travel expenses. A beneficiary must submit a request for
8 reimbursement within 2 weeks of the treatment and may
9 appeal any denial of reimbursement claims.

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

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

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

26 (f) The network plan may consider use of other health care

1 service delivery options, such as telemedicine or telehealth,
2 mobile clinics, and centers of excellence, or other ways of
3 delivering care to partially meet the requirements set under
4 this Section.

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

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

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

1 the physicians currently refer beneficiaries, or both; or

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

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

19 (i) If a network plan is inadequate under this Act with
20 respect to a provider type in a county, and if the network plan
21 does not have an approved exception for that provider type in
22 that county pursuant to subsection (g), an issuer shall cover
23 out-of-network claims for covered health care services
24 received from that provider type within that county at the
25 in-network benefit level and shall retroactively adjudicate
26 and reimburse beneficiaries to achieve that objective if their

1 claims were processed at the out-of-network level contrary to
2 this subsection. Nothing in this subsection shall be construed
3 to supersede Section 356z.3a of the Illinois Insurance Code.

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

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

25 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
26 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

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

2 Sec. 10. Network adequacy.

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

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

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

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

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

24 (b) Insurers must file for review a description of the
25 services to be offered through a network plan. The description

1 shall include all of the following:

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

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

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

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

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

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

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

1 enrolled population;

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

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

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

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

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

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

26 (c) The network plan shall demonstrate to the Director a

1 minimum ratio of providers to plan beneficiaries as required
2 by the Department.

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

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

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

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

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

1 or rural counties as defined by Department rule.

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

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

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

1 Act of 2008. Notwithstanding the foregoing, the network
2 adequacy standards for timely and proximate access to
3 treatment for mental, emotional, nervous, or substance use
4 disorders or conditions shall, at a minimum, satisfy the
5 following requirements:

6 (A) For beneficiaries residing in the metropolitan
7 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
8 network adequacy standards for timely and proximate access
9 to treatment for mental, emotional, nervous, or substance
10 use disorders or conditions means a beneficiary shall not
11 have to travel longer than 30 minutes or 30 miles from the
12 beneficiary's residence to receive outpatient treatment
13 for mental, emotional, nervous, or substance use disorders
14 or conditions. Beneficiaries shall not be required to wait
15 longer than 10 business days between requesting an initial
16 appointment and being seen by the facility or provider of
17 mental, emotional, nervous, or substance use disorders or
18 conditions for outpatient treatment 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 (B) For beneficiaries residing in Illinois counties
2 other than those counties listed in subparagraph (A) of
3 this paragraph, network adequacy standards for timely and
4 proximate access to treatment for mental, emotional,
5 nervous, or substance use disorders or conditions means a
6 beneficiary shall not have to travel longer than 60
7 minutes or 60 miles from the beneficiary's residence to
8 receive outpatient treatment for mental, emotional,
9 nervous, or substance use disorders or conditions.
10 Beneficiaries shall not be required to wait longer than 10
11 business days between requesting an initial appointment
12 and being seen by the facility or provider of mental,
13 emotional, nervous, or substance use disorders or
14 conditions for outpatient treatment or to wait longer than
15 20 business days between requesting a repeat or follow-up
16 appointment and being seen by the facility or provider of
17 mental, emotional, nervous, or substance use disorders or
18 conditions for outpatient treatment; however, subject to
19 the protections of paragraph (3) of this subsection, a
20 network plan shall not be held responsible if the
21 beneficiary or provider voluntarily chooses to schedule an
22 appointment outside of these required time frames.

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

1 travel longer than 60 minutes or 60 miles from the
2 beneficiary's residence to receive inpatient or residential
3 treatment for mental, emotional, nervous, or substance use
4 disorders or conditions.

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

14 (A) For plan or policy years beginning on or after
15 January 1, 2026, the issuer also shall provide reasonable
16 reimbursement to a beneficiary for costs including food,
17 lodging, and travel. Reimbursement for food and lodging
18 shall be at the prevailing federal per diem rates, then in
19 effect, as set by the United States General Services
20 Administration. Reimbursement for travel by vehicle shall
21 be reimbursed at the current Internal Revenue Service
22 mileage standard for miles driven for transportation or
23 travel expenses. A beneficiary must submit a request for
24 reimbursement within 2 weeks of the treatment and may
25 appeal any denial of reimbursement claims.

26 (B) Notwithstanding anything in this Section to the

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

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

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

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

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

1 or facility;

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

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

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

18 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
19 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

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

21 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 applicable.

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

1 participating providers under the circumstances described
2 in subsection (b) or (b-5) of Section 356z.3a of the
3 Illinois Insurance Code except under the circumstances
4 described in paragraph (2) of subsection (b-5).

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

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

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

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

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

8 (A) Primary Care;

9 (B) Pediatrics;

10 (C) Cardiology;

11 (D) Gastroenterology;

12 (E) General Surgery;

13 (F) Neurology;

14 (G) OB/GYN;

15 (H) Oncology/Radiation;

16 (I) Ophthalmology;

17 (J) Urology;

18 (K) Behavioral Health;

19 (L) Allergy/Immunology;

20 (M) Chiropractic;

21 (N) Dermatology;

22 (O) Endocrinology;

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

24 (Q) Infectious Disease;

25 (R) Nephrology;

26 (S) Neurosurgery;

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

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

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

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

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

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

1 following requirements:

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

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

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

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

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

10 (A) For plan or policy years beginning on or after
11 January 1, 2026, the issuer also shall provide reasonable
12 reimbursement to a beneficiary for costs including food,
13 lodging, and travel. Reimbursement for food and lodging
14 shall be at the prevailing federal per diem rates, then in
15 effect, as set by the United States General Services
16 Administration. Reimbursement for travel by vehicle shall
17 be reimbursed at the current Internal Revenue Service
18 mileage standard for miles driven for transportation or
19 travel expenses. A beneficiary must submit a request for
20 reimbursement within 2 weeks of the treatment and may
21 appeal any denial of reimbursement claims.

22 (B) Notwithstanding anything in this Section to the
23 contrary, subparagraph (A) of this paragraph (3) does not
24 apply to policies issued or delivered in this State that
25 provide medical assistance under the Illinois Public Aid
26 Code or the Children's 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; 103-718, eff. 7-19-24.)

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

17 Sec. 10. Network adequacy.

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

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

25 (2) The written policies and procedures for making

1 referrals within and outside the network.

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

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

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

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

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

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

26 (4) An Internet website and toll-free telephone number

1 for beneficiaries and prospective beneficiaries to access
2 current and accurate lists of preferred providers,
3 additional information about the plan, as well as any
4 other information required by Department rule.

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

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

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

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

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

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

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

26 (7) A provision that the beneficiary shall receive

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

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

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

20 (1) The ratio of physicians or other providers to plan
21 beneficiaries shall be established annually 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) If the federal Centers for Medicare and Medicaid
13 Services establishes minimum provider ratios for
14 stand-alone dental plans in the type of exchange in use in
15 this State for a given plan year, the Department shall
16 enforce those standards for stand-alone dental plans for
17 that plan year.

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

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

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

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

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

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

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

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

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

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

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

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

24 (A) For plan or policy years beginning on or after
25 January 1, 2026, the issuer also shall provide reasonable
26 reimbursement to a beneficiary for costs including food,

1 lodging, and travel. Reimbursement for food and lodging
2 shall be at the prevailing federal per diem rates, then in
3 effect, as set by the United States General Services
4 Administration. Reimbursement for travel by vehicle shall
5 be reimbursed at the current Internal Revenue Service
6 mileage standard for miles driven for transportation or
7 travel expenses. A beneficiary must submit a request for
8 reimbursement within 2 weeks of the treatment and may
9 appeal any denial of reimbursement claims.

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

15 (4) If the federal Centers for Medicare and Medicaid
16 Services establishes a more stringent standard in any county
17 than specified in paragraph (1) or (2) of this subsection
18 (d-5) for qualified health plans in the type of exchange in use
19 in this State for a given plan year, the federal standard shall
20 apply in lieu of the standard in paragraph (1) or (2) of this
21 subsection (d-5) for qualified health plans for that plan
22 year.

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

26 (f) The network plan may consider use of other health care

1 service delivery options, such as telemedicine or telehealth,
2 mobile clinics, and centers of excellence, or other ways of
3 delivering care to partially meet the requirements set under
4 this Section.

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

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

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

1 the physicians currently refer beneficiaries, or both; or

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

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

11 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
12 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

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

14 Sec. 10. Network adequacy.

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

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

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

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

1 to network-affiliated primary care, emergency services,
2 and women's principal health care providers.

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

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

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

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

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

23 (4) An Internet website and toll-free telephone number
24 for beneficiaries and prospective beneficiaries to access
25 current and accurate lists of preferred providers,
26 additional information about the plan, as well as any

1 other information required by Department rule.

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

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

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

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

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

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

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

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

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

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

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

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

26 (A) Primary Care;

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

1 (BB) Outpatient Dialysis; and

2 (CC) HIV.

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

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

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

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

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

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

1 following requirements:

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

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

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

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

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

10 (A) For plan or policy years beginning on or after
11 January 1, 2026, the issuer also shall provide reasonable
12 reimbursement to a beneficiary for costs including food,
13 lodging, and travel. Reimbursement for food and lodging
14 shall be at the prevailing federal per diem rates, then in
15 effect, as set by the United States General Services
16 Administration. Reimbursement for travel by vehicle shall
17 be reimbursed at the current Internal Revenue Service
18 mileage standard for miles driven for transportation or
19 travel expenses. A beneficiary must submit a request for
20 reimbursement within 2 weeks of the treatment and may
21 appeal any denial of reimbursement claims.

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