

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Sections 121-2.08, 174, 194, 368d, 370c.1, and 1563
6 and by renumbering and changing Section 356z.71 (as amended by
7 Public Act 103-700) as follows:

8 (215 ILCS 5/121-2.08) (from Ch. 73, par. 733-2.08)

9 Sec. 121-2.08. Transactions in this State involving
10 contracts of insurance independently procured directly from an
11 unauthorized insurer by industrial insureds.

12 (a) As used in this Section:

13 "Exempt commercial purchaser" means exempt commercial
14 purchaser as the term is defined in subsection (1) of Section
15 445 of this Code.

16 "Home state" means home state as the term is defined in
17 subsection (1) of Section 445 of this Code.

18 "Industrial insured" means an insured:

19 (i) that procures the insurance of any risk or risks
20 of the kinds specified in Classes 2 and 3 of Section 4 of
21 this Code by use of the services of a full-time employee
22 who is a qualified risk manager or the services of a
23 regularly and continuously retained consultant who is a

1 qualified risk manager;

2 (ii) that procures the insurance ~~directly from an~~
3 ~~unauthorized insurer~~ without the services of an
4 intermediary insurance producer; and

5 (iii) that is an exempt commercial purchaser whose
6 home state is Illinois.

7 "Insurance producer" means insurance producer as the term
8 is defined in Section 500-10 of this Code.

9 "Qualified risk manager" means qualified risk manager as
10 the term is defined in subsection (1) of Section 445 of this
11 Code.

12 "Safety-Net Hospital" means an Illinois hospital that
13 qualifies as a Safety-Net Hospital under Section 5-5e.1 of the
14 Illinois Public Aid Code.

15 "Unauthorized insurer" means unauthorized insurer as the
16 term is defined in subsection (1) of Section 445 of this Code.

17 (b) For contracts of insurance procured directly from an
18 unauthorized insurer effective January 1, 2015 or later,
19 within 90 days after the effective date of each contract of
20 insurance issued under this Section, the insured shall file a
21 report with the Director by submitting the report to the
22 Surplus Line Association of Illinois in writing or in a
23 computer readable format and provide information as designated
24 by the Surplus Line Association of Illinois. The information
25 in the report shall be substantially similar to that required
26 for surplus line submissions as described in subsection (5) of

1 Section 445 of this Code. Where applicable, the report shall
2 satisfy, with respect to the subject insurance, the reporting
3 requirement of Section 12 of the Fire Investigation Act.

4 (c) For contracts of insurance procured directly from an
5 unauthorized insurer effective January 1, 2015 through
6 December 31, 2017, within 30 days after filing the report, the
7 insured shall pay to the Director for the use and benefit of
8 the State a sum equal to the gross premium of the contract of
9 insurance multiplied by the surplus line tax rate, as
10 described in paragraph (3) of subsection (a) of Section 445 of
11 this Code, and shall pay the fire marshal tax that would
12 otherwise be due annually in March for insurance subject to
13 tax under Section 12 of the Fire Investigation Act. For
14 contracts of insurance procured directly from an unauthorized
15 insurer effective January 1, 2018 or later, within 30 days
16 after filing the report, the insured shall pay to the Director
17 for the use and benefit of the State a sum equal to 0.5% of the
18 gross premium of the contract of insurance, and shall pay the
19 fire marshal tax that would otherwise be due annually in March
20 for insurance subject to tax under Section 12 of the Fire
21 Investigation Act. For contracts of insurance procured
22 directly from an unauthorized insurer effective January 1,
23 2015 or later, within 30 days after filing the report, the
24 insured shall pay to the Surplus Line Association of Illinois
25 a countersigning fee that shall be assessed at the same rate
26 charged to members pursuant to subsection (4) of Section 445.1

1 of this Code.

2 (d) For contracts of insurance procured directly from an
3 unauthorized insurer effective January 1, 2015 or later, the
4 insured shall withhold the amount of the taxes and
5 countersignature fee from the amount of premium charged by and
6 otherwise payable to the insurer for the insurance. If the
7 insured fails to withhold the tax and countersignature fee
8 from the premium, then the insured shall be liable for the
9 amounts thereof and shall pay the amounts as prescribed in
10 subsection (c) of this Section.

11 (e) Contracts of insurance with an industrial insured that
12 qualifies as a Safety-Net Hospital are not subject to
13 subsections (b) through (d) of this Section.

14 (Source: P.A. 100-535, eff. 9-22-17; 100-1118, eff. 11-27-18.)

15 (215 ILCS 5/174) (from Ch. 73, par. 786)

16 Sec. 174. Kinds of agreements requiring approval.

17 (1) The following kinds of reinsurance agreements shall
18 not be entered into by any domestic company unless such
19 agreements are approved in writing by the Director:

20 (a) Agreements of reinsurance of any such company
21 transacting the kind or kinds of business enumerated in
22 Class 1 of Section 4, or as a Fraternal Benefit Society
23 under Article XVII, a Mutual Benefit Association under
24 Article XVIII, a Burial Society under Article XIX or an
25 Assessment Accident and Assessment Accident and Health

1 Company under Article XXI, cedes previously issued and
2 outstanding risks to any company, or cedes any risks to a
3 company not authorized to transact business in this State,
4 or assumes any outstanding risks on which the aggregate
5 reserves and claim liabilities exceed 20% ~~20 percent~~ of
6 the aggregate reserves and claim liabilities of the
7 assuming company, as reported in the preceding annual
8 statement, for the business of either life or accident and
9 health insurance.

10 (b) Any agreement or agreements of reinsurance whereby
11 any company transacting the kind or kinds of business
12 enumerated in either Class 2 or Class 3 of Section 4 cedes
13 to any company or companies at one time, or during a period
14 of six consecutive months more than 20% ~~twenty per centum~~
15 of the total amount of its net ~~previously retained~~
16 unearned premium reserve liability. The Director has the
17 right to request additional filing review and approval of
18 all contracts that contribute to the statutory threshold
19 trigger. As used in this Section, "net unearned premium
20 reserve liability" means a liability associated with
21 existing or in-force business that is not ceded to any
22 reinsurer before the effective date of the proposed
23 reinsurance contract.

24 (c) (Blank).

25 (2) Requests for approval shall be filed at least 30
26 working days prior to the stated effective date of the

1 agreement. An agreement which is not disapproved by the
2 Director within 30 working ~~thirty~~ days after its complete
3 submission shall be deemed approved.

4 (Source: P.A. 98-969, eff. 1-1-15.)

5 (215 ILCS 5/194) (from Ch. 73, par. 806)

6 Sec. 194. Rights and liabilities of creditors fixed upon
7 liquidation.

8 (a) The rights and liabilities of the company and of its
9 creditors, policyholders, stockholders or members and all
10 other persons interested in its assets, except persons
11 entitled to file contingent claims, shall be fixed as of the
12 date of the entry of the Order directing liquidation or
13 rehabilitation unless otherwise provided by Order of the
14 Court. The rights of claimants entitled to file contingent
15 claims or to have their claims estimated shall be determined
16 as provided in Section 209.

17 (b) The Director may, within 2 years after the entry of an
18 order for rehabilitation or liquidation or within such further
19 time as applicable law permits, institute an action, claim,
20 suit, or proceeding upon any cause of action against which the
21 period of limitation fixed by applicable law has not expired
22 at the time of filing of the complaint upon which the order is
23 entered.

24 (c) The time between the filing of a complaint for
25 conservation, rehabilitation, or liquidation against the

1 company and the denial of the complaint shall not be
2 considered to be a part of the time within which any action may
3 be commenced against the company. Any action against the
4 company that might have been commenced when the complaint was
5 filed may be commenced for at least 180 days after the
6 complaint is denied.

7 (d) Notwithstanding subsection (a) of this Section,
8 policies of life, disability income, long-term care, health
9 insurance or annuities covered by a guaranty association, or
10 portions of such policies covered by one or more guaranty
11 associations under applicable law shall continue in force,
12 subject to the terms of the policy (including any terms
13 restructured pursuant to a court-approved rehabilitation plan)
14 to the extent necessary to permit the guaranty associations to
15 discharge their statutory obligations. Policies of life,
16 disability income, long-term care, health insurance or
17 annuities, or portions of such policies not covered by one or
18 more guaranty associations shall terminate as provided under
19 subsection (a) of this Section and paragraph (6) of Section
20 193 of this Article, except to the extent the Director
21 proposes and the court approves the use of property of the
22 liquidation estate for the purpose of either (1) continuing
23 the contracts or coverage by transferring them to an assuming
24 reinsurer, or (2) distributing dividends under Section 210 of
25 this Article. Claims incurred during the extension of coverage
26 provided for in this Article shall be classified at priority

1 level (d) under paragraph (1) of Section 205 of this Article.

2 (Source: P.A. 88-297; 89-206, eff. 7-21-95.)

3 (215 ILCS 5/356z.73)

4 Sec. 356z.73 ~~356z.71~~. Insurance coverage for dependent
5 parents.

6 (a) A group or individual policy of accident and health
7 insurance issued, amended, delivered, or renewed on or after
8 January 1, 2026 that provides dependent coverage shall make
9 that dependent coverage available to the parent or stepparent
10 of the insured if the parent or stepparent meets the
11 definition of a qualifying relative under 26 U.S.C. 152(d) and
12 lives or resides within the accident and health insurance
13 policy's service area.

14 (b) This Section does not apply to specialized health care
15 service plans, Medicare supplement insurance, hospital-only
16 policies, accident-only policies, or specified disease
17 insurance policies that reimburse for hospital, medical, or
18 surgical expenses.

19 (Source: P.A. 103-700, eff. 1-1-25; revised 12-3-24.)

20 (215 ILCS 5/368d)

21 Sec. 368d. Recoupments.

22 (a) A health care professional or health care provider
23 shall be provided a remittance advice, which must include an
24 explanation of a recoupment or offset taken by an insurer,

1 health maintenance organization, independent practice
2 association, or physician hospital organization, if any. The
3 recoupment explanation shall, at a minimum, include the name
4 of the patient; the date of service; the service code or if no
5 service code is available a service description; the
6 recoupment amount; and the reason for the recoupment or
7 offset. In addition, an insurer, health maintenance
8 organization, independent practice association, or physician
9 hospital organization shall provide with the remittance
10 advice, or with any demand for recoupment or offset, a
11 telephone number or mailing address to initiate an appeal of
12 the recoupment or offset together with the deadline for
13 initiating an appeal. Such information shall be prominently
14 displayed on the remittance advice or written document
15 containing the demand for recoupment or offset. Any appeal of
16 a recoupment or offset by a health care professional or health
17 care provider must be made within 60 days after receipt of the
18 remittance advice.

19 (b) It is not a recoupment when a health care professional
20 or health care provider is paid an amount prospectively or
21 concurrently under a contract with an insurer, health
22 maintenance organization, independent practice association, or
23 physician hospital organization that requires a retrospective
24 reconciliation based upon specific conditions outlined in the
25 contract.

26 (c) No recoupment or offset may be requested or withheld

1 from future payments 12 months or more after the original
2 payment is made, except in cases in which:

3 (1) a court, government administrative agency, other
4 tribunal, or independent third-party arbitrator makes or
5 has made a formal finding of fraud or material
6 misrepresentation;

7 (2) an insurer is acting as a plan administrator for
8 the Comprehensive Health Insurance Plan under the
9 Comprehensive Health Insurance Plan Act;

10 (3) the provider has already been paid in full by any
11 other payer, third party, or workers' compensation
12 insurer; or

13 (4) an insurer contracted with the Department of
14 Healthcare and Family Services is required by the
15 Department of Healthcare and Family Services to recoup or
16 offset payments due to a federal Medicaid requirement.

17 No contract between an insurer and a health care professional
18 or health care provider may provide for recoupments in
19 violation of this Section. Nothing in this Section shall be
20 construed to preclude insurers, health maintenance
21 organizations, independent practice associations, or physician
22 hospital organizations from resolving coordination of benefits
23 between or among each other, including, but not limited to,
24 resolution of workers' compensation and third-party liability
25 cases, without recouping payment from the provider beyond the
26 12-month ~~18-month~~ time limit provided in this subsection (c).

1 (Source: P.A. 102-632, eff. 1-1-22.)

2 (215 ILCS 5/370c.1)

3 Sec. 370c.1. Mental, emotional, nervous, or substance use
4 disorder or condition parity.

5 (a) On and after July 23, 2021 (the effective date of
6 Public Act 102-135), every insurer that amends, delivers,
7 issues, or renews a group or individual policy of accident and
8 health insurance or a qualified health plan offered through
9 the Health Insurance Marketplace in this State providing
10 coverage for hospital or medical treatment and for the
11 treatment of mental, emotional, nervous, or substance use
12 disorders or conditions shall ensure prior to policy issuance
13 that:

14 (1) the financial requirements applicable to such
15 mental, emotional, nervous, or substance use disorder or
16 condition benefits are no more restrictive than the
17 predominant financial requirements applied to
18 substantially all hospital and medical benefits covered by
19 the policy and that there are no separate cost-sharing
20 requirements that are applicable only with respect to
21 mental, emotional, nervous, or substance use disorder or
22 condition benefits; and

23 (2) the treatment limitations applicable to such
24 mental, emotional, nervous, or substance use disorder or
25 condition benefits are no more restrictive than the

1 predominant treatment limitations applied to substantially
2 all hospital and medical benefits covered by the policy
3 and that there are no separate treatment limitations that
4 are applicable only with respect to mental, emotional,
5 nervous, or substance use disorder or condition benefits.

6 (b) The following provisions shall apply concerning
7 aggregate lifetime limits:

8 (1) In the case of a group or individual policy of
9 accident and health insurance or a qualified health plan
10 offered through the Health Insurance Marketplace amended,
11 delivered, issued, or renewed in this State on or after
12 September 9, 2015 (the effective date of Public Act
13 99-480) that provides coverage for hospital or medical
14 treatment and for the treatment of mental, emotional,
15 nervous, or substance use disorders or conditions the
16 following provisions shall apply:

17 (A) if the policy does not include an aggregate
18 lifetime limit on substantially all hospital and
19 medical benefits, then the policy may not impose any
20 aggregate lifetime limit on mental, emotional,
21 nervous, or substance use disorder or condition
22 benefits; or

23 (B) if the policy includes an aggregate lifetime
24 limit on substantially all hospital and medical
25 benefits (in this subsection referred to as the
26 "applicable lifetime limit"), then the policy shall

1 either:

2 (i) apply the applicable lifetime limit both
3 to the hospital and medical benefits to which it
4 otherwise would apply and to mental, emotional,
5 nervous, or substance use disorder or condition
6 benefits and not distinguish in the application of
7 the limit between the hospital and medical
8 benefits and mental, emotional, nervous, or
9 substance use disorder or condition benefits; or

10 (ii) not include any aggregate lifetime limit
11 on mental, emotional, nervous, or substance use
12 disorder or condition benefits that is less than
13 the applicable lifetime limit.

14 (2) In the case of a policy that is not described in
15 paragraph (1) of subsection (b) of this Section and that
16 includes no or different aggregate lifetime limits on
17 different categories of hospital and medical benefits, the
18 Director shall establish rules under which subparagraph
19 (B) of paragraph (1) of subsection (b) of this Section is
20 applied to such policy with respect to mental, emotional,
21 nervous, or substance use disorder or condition benefits
22 by substituting for the applicable lifetime limit an
23 average aggregate lifetime limit that is computed taking
24 into account the weighted average of the aggregate
25 lifetime limits applicable to such categories.

26 (c) The following provisions shall apply concerning annual

1 limits:

2 (1) In the case of a group or individual policy of
3 accident and health insurance or a qualified health plan
4 offered through the Health Insurance Marketplace amended,
5 delivered, issued, or renewed in this State on or after
6 September 9, 2015 (the effective date of Public Act
7 99-480) that provides coverage for hospital or medical
8 treatment and for the treatment of mental, emotional,
9 nervous, or substance use disorders or conditions the
10 following provisions shall apply:

11 (A) if the policy does not include an annual limit
12 on substantially all hospital and medical benefits,
13 then the policy may not impose any annual limits on
14 mental, emotional, nervous, or substance use disorder
15 or condition benefits; or

16 (B) if the policy includes an annual limit on
17 substantially all hospital and medical benefits (in
18 this subsection referred to as the "applicable annual
19 limit"), then the policy shall either:

20 (i) apply the applicable annual limit both to
21 the hospital and medical benefits to which it
22 otherwise would apply and to mental, emotional,
23 nervous, or substance use disorder or condition
24 benefits and not distinguish in the application of
25 the limit between the hospital and medical
26 benefits and mental, emotional, nervous, or

1 substance use disorder or condition benefits; or

2 (ii) not include any annual limit on mental,
3 emotional, nervous, or substance use disorder or
4 condition benefits that is less than the
5 applicable annual limit.

6 (2) In the case of a policy that is not described in
7 paragraph (1) of subsection (c) of this Section and that
8 includes no or different annual limits on different
9 categories of hospital and medical benefits, the Director
10 shall establish rules under which subparagraph (B) of
11 paragraph (1) of subsection (c) of this Section is applied
12 to such policy with respect to mental, emotional, nervous,
13 or substance use disorder or condition benefits by
14 substituting for the applicable annual limit an average
15 annual limit that is computed taking into account the
16 weighted average of the annual limits applicable to such
17 categories.

18 (d) With respect to mental, emotional, nervous, or
19 substance use disorders or conditions, an insurer shall use
20 policies and procedures for the election and placement of
21 mental, emotional, nervous, or substance use disorder or
22 condition treatment drugs on their formulary that are no less
23 favorable to the insured as those policies and procedures the
24 insurer uses for the selection and placement of drugs for
25 medical or surgical conditions and shall follow the expedited
26 coverage determination requirements for substance abuse

1 treatment drugs set forth in Section 45.2 of the Managed Care
2 Reform and Patient Rights Act.

3 (e) This Section shall be interpreted in a manner
4 consistent with all applicable federal parity regulations
5 including, but not limited to, the Paul Wellstone and Pete
6 Domenici Mental Health Parity and Addiction Equity Act of
7 2008, final regulations issued under the Paul Wellstone and
8 Pete Domenici Mental Health Parity and Addiction Equity Act of
9 2008 and final regulations applying the Paul Wellstone and
10 Pete Domenici Mental Health Parity and Addiction Equity Act of
11 2008 to Medicaid managed care organizations, the Children's
12 Health Insurance Program, and alternative benefit plans.

13 (f) The provisions of subsections (b) and (c) of this
14 Section shall not be interpreted to allow the use of lifetime
15 or annual limits otherwise prohibited by State or federal law.

16 (g) As used in this Section:

17 "Financial requirement" includes deductibles, copayments,
18 coinsurance, and out-of-pocket maximums, but does not include
19 an aggregate lifetime limit or an annual limit subject to
20 subsections (b) and (c).

21 "Mental, emotional, nervous, or substance use disorder or
22 condition" means a condition or disorder that involves a
23 mental health condition or substance use disorder that falls
24 under any of the diagnostic categories listed in the mental
25 and behavioral disorders chapter of the current edition of the
26 International Classification of Disease or that is listed in

1 the most recent version of the Diagnostic and Statistical
2 Manual of Mental Disorders.

3 "Treatment limitation" includes limits on benefits based
4 on the frequency of treatment, number of visits, days of
5 coverage, days in a waiting period, or other similar limits on
6 the scope or duration of treatment. "Treatment limitation"
7 includes both quantitative treatment limitations, which are
8 expressed numerically (such as 50 outpatient visits per year),
9 and nonquantitative treatment limitations, which otherwise
10 limit the scope or duration of treatment. A permanent
11 exclusion of all benefits for a particular condition or
12 disorder shall not be considered a treatment limitation.
13 "Nonquantitative treatment" means those limitations as
14 described under federal regulations (26 CFR 54.9812-1).
15 "Nonquantitative treatment limitations" include, but are not
16 limited to, those limitations described under federal
17 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
18 146.136.

19 (h) The Department of Insurance shall implement the
20 following education initiatives:

21 (1) By January 1, 2016, the Department shall develop a
22 plan for a Consumer Education Campaign on parity. The
23 Consumer Education Campaign shall focus its efforts
24 throughout the State and include trainings in the
25 northern, southern, and central regions of the State, as
26 defined by the Department, as well as each of the 5 managed

1 care regions of the State as identified by the Department
2 of Healthcare and Family Services. Under this Consumer
3 Education Campaign, the Department shall: (1) by January
4 1, 2017, provide at least one live training in each region
5 on parity for consumers and providers and one webinar
6 training to be posted on the Department website and (2)
7 establish a consumer hotline to assist consumers in
8 navigating the parity process by March 1, 2017. By January
9 1, 2018 the Department shall issue a report to the General
10 Assembly on the success of the Consumer Education
11 Campaign, which shall indicate whether additional training
12 is necessary or would be recommended.

13 (2) (Blank). ~~The Department, in coordination with the~~
14 ~~Department of Human Services and the Department of~~
15 ~~Healthcare and Family Services, shall convene a working~~
16 ~~group of health care insurance carriers, mental health~~
17 ~~advocacy groups, substance abuse patient advocacy groups,~~
18 ~~and mental health physician groups for the purpose of~~
19 ~~discussing issues related to the treatment and coverage of~~
20 ~~mental, emotional, nervous, or substance use disorders or~~
21 ~~conditions and compliance with parity obligations under~~
22 ~~State and federal law. Compliance shall be measured,~~
23 ~~tracked, and shared during the meetings of the working~~
24 ~~group. The working group shall meet once before January 1,~~
25 ~~2016 and shall meet semiannually thereafter. The~~
26 ~~Department shall issue an annual report to the General~~

1 ~~Assembly that includes a list of the health care insurance~~
2 ~~carriers, mental health advocacy groups, substance abuse~~
3 ~~patient advocacy groups, and mental health physician~~
4 ~~groups that participated in the working group meetings,~~
5 ~~details on the issues and topics covered, and any~~
6 ~~legislative recommendations developed by the working~~
7 ~~group.~~

8 (3) Not later than January 1 of each year, the
9 Department, in conjunction with the Department of
10 Healthcare and Family Services, shall issue a joint report
11 to the General Assembly and provide an educational
12 presentation to the General Assembly. The report and
13 presentation shall:

14 (A) Cover the methodology the Departments use to
15 check for compliance with the federal Paul Wellstone
16 and Pete Domenici Mental Health Parity and Addiction
17 Equity Act of 2008, 42 U.S.C. 18031(j), and any
18 federal regulations or guidance relating to the
19 compliance and oversight of the federal Paul Wellstone
20 and Pete Domenici Mental Health Parity and Addiction
21 Equity Act of 2008 and 42 U.S.C. 18031(j).

22 (B) Cover the methodology the Departments use to
23 check for compliance with this Section and Sections
24 356z.23 and 370c of this Code.

25 (C) Identify market conduct examinations or, in
26 the case of the Department of Healthcare and Family

1 Services, audits conducted or completed during the
2 preceding 12-month period regarding compliance with
3 parity in mental, emotional, nervous, and substance
4 use disorder or condition benefits under State and
5 federal laws and summarize the results of such market
6 conduct examinations and audits. This shall include:

7 (i) the number of market conduct examinations
8 and audits initiated and completed;

9 (ii) the benefit classifications examined by
10 each market conduct examination and audit;

11 (iii) the subject matter of each market
12 conduct examination and audit, including
13 quantitative and nonquantitative treatment
14 limitations; and

15 (iv) a summary of the basis for the final
16 decision rendered in each market conduct
17 examination and audit.

18 Individually identifiable information shall be
19 excluded from the reports consistent with federal
20 privacy protections.

21 (D) Detail any educational or corrective actions
22 the Departments have taken to ensure compliance with
23 the federal Paul Wellstone and Pete Domenici Mental
24 Health Parity and Addiction Equity Act of 2008, 42
25 U.S.C. 18031(j), this Section, and Sections 356z.23
26 and 370c of this Code.

1 (E) The report must be written in non-technical,
2 readily understandable language and shall be made
3 available to the public by, among such other means as
4 the Departments find appropriate, posting the report
5 on the Departments' websites.

6 (i) The Parity Advancement Fund is created as a special
7 fund in the State treasury. Moneys from fines and penalties
8 collected from insurers for violations of this Section shall
9 be deposited into the Fund. Moneys deposited into the Fund for
10 appropriation by the General Assembly to the Department shall
11 be used for the purpose of providing financial support of the
12 Consumer Education Campaign, parity compliance advocacy, and
13 other initiatives that support parity implementation and
14 enforcement on behalf of consumers.

15 (j) (Blank).

16 (j-5) The Department of Insurance shall collect the
17 following information:

18 (1) The number of employment disability insurance
19 plans offered in this State, including, but not limited
20 to:

21 (A) individual short-term policies;

22 (B) individual long-term policies;

23 (C) group short-term policies; and

24 (D) group long-term policies.

25 (2) The number of policies referenced in paragraph (1)
26 of this subsection that limit mental health and substance

1 use disorder benefits.

2 (3) The average defined benefit period for the
3 policies referenced in paragraph (1) of this subsection,
4 both for those policies that limit and those policies that
5 have no limitation on mental health and substance use
6 disorder benefits.

7 (4) Whether the policies referenced in paragraph (1)
8 of this subsection are purchased on a voluntary or
9 non-voluntary basis.

10 (5) The identities of the individuals, entities, or a
11 combination of the 2 that assume the cost associated with
12 covering the policies referenced in paragraph (1) of this
13 subsection.

14 (6) The average defined benefit period for plans that
15 cover physical disability and mental health and substance
16 abuse without limitation, including, but not limited to:

17 (A) individual short-term policies;

18 (B) individual long-term policies;

19 (C) group short-term policies; and

20 (D) group long-term policies.

21 (7) The average premiums for disability income
22 insurance issued in this State for:

23 (A) individual short-term policies that limit
24 mental health and substance use disorder benefits;

25 (B) individual long-term policies that limit
26 mental health and substance use disorder benefits;

1 (C) group short-term policies that limit mental
2 health and substance use disorder benefits;

3 (D) group long-term policies that limit mental
4 health and substance use disorder benefits;

5 (E) individual short-term policies that include
6 mental health and substance use disorder benefits
7 without limitation;

8 (F) individual long-term policies that include
9 mental health and substance use disorder benefits
10 without limitation;

11 (G) group short-term policies that include mental
12 health and substance use disorder benefits without
13 limitation; and

14 (H) group long-term policies that include mental
15 health and substance use disorder benefits without
16 limitation.

17 The Department shall present its findings regarding
18 information collected under this subsection (j-5) to the
19 General Assembly no later than April 30, 2024. Information
20 regarding a specific insurance provider's contributions to the
21 Department's report shall be exempt from disclosure under
22 paragraph (t) of subsection (1) of Section 7 of the Freedom of
23 Information Act. The aggregated information gathered by the
24 Department shall not be exempt from disclosure under paragraph
25 (t) of subsection (1) of Section 7 of the Freedom of
26 Information Act.

1 (k) An insurer that amends, delivers, issues, or renews a
2 group or individual policy of accident and health insurance or
3 a qualified health plan offered through the health insurance
4 marketplace in this State providing coverage for hospital or
5 medical treatment and for the treatment of mental, emotional,
6 nervous, or substance use disorders or conditions shall submit
7 an annual report, the format and definitions for which will be
8 determined by the Department and the Department of Healthcare
9 and Family Services and posted on their respective websites,
10 starting on September 1, 2023 and annually thereafter, that
11 contains the following information separately for inpatient
12 in-network benefits, inpatient out-of-network benefits,
13 outpatient in-network benefits, outpatient out-of-network
14 benefits, emergency care benefits, and prescription drug
15 benefits in the case of accident and health insurance or
16 qualified health plans, or inpatient, outpatient, emergency
17 care, and prescription drug benefits in the case of medical
18 assistance:

19 (1) A summary of the plan's pharmacy management
20 processes for mental, emotional, nervous, or substance use
21 disorder or condition benefits compared to those for other
22 medical benefits.

23 (2) A summary of the internal processes of review for
24 experimental benefits and unproven technology for mental,
25 emotional, nervous, or substance use disorder or condition
26 benefits and those for other medical benefits.

1 (3) A summary of how the plan's policies and
2 procedures for utilization management for mental,
3 emotional, nervous, or substance use disorder or condition
4 benefits compare to those for other medical benefits.

5 (4) A description of the process used to develop or
6 select the medical necessity criteria for mental,
7 emotional, nervous, or substance use disorder or condition
8 benefits and the process used to develop or select the
9 medical necessity criteria for medical and surgical
10 benefits.

11 (5) Identification of all nonquantitative treatment
12 limitations that are applied to both mental, emotional,
13 nervous, or substance use disorder or condition benefits
14 and medical and surgical benefits within each
15 classification of benefits.

16 (6) The results of an analysis that demonstrates that
17 for the medical necessity criteria described in
18 subparagraph (A) and for each nonquantitative treatment
19 limitation identified in subparagraph (B), as written and
20 in operation, the processes, strategies, evidentiary
21 standards, or other factors used in applying the medical
22 necessity criteria and each nonquantitative treatment
23 limitation to mental, emotional, nervous, or substance use
24 disorder or condition benefits within each classification
25 of benefits are comparable to, and are applied no more
26 stringently than, the processes, strategies, evidentiary

1 standards, or other factors used in applying the medical
2 necessity criteria and each nonquantitative treatment
3 limitation to medical and surgical benefits within the
4 corresponding classification of benefits; at a minimum,
5 the results of the analysis shall:

6 (A) identify the factors used to determine that a
7 nonquantitative treatment limitation applies to a
8 benefit, including factors that were considered but
9 rejected;

10 (B) identify and define the specific evidentiary
11 standards used to define the factors and any other
12 evidence relied upon in designing each nonquantitative
13 treatment limitation;

14 (C) provide the comparative analyses, including
15 the results of the analyses, performed to determine
16 that the processes and strategies used to design each
17 nonquantitative treatment limitation, as written, for
18 mental, emotional, nervous, or substance use disorder
19 or condition benefits are comparable to, and are
20 applied no more stringently than, the processes and
21 strategies used to design each nonquantitative
22 treatment limitation, as written, for medical and
23 surgical benefits;

24 (D) provide the comparative analyses, including
25 the results of the analyses, performed to determine
26 that the processes and strategies used to apply each

1 nonquantitative treatment limitation, in operation,
2 for mental, emotional, nervous, or substance use
3 disorder or condition benefits are comparable to, and
4 applied no more stringently than, the processes or
5 strategies used to apply each nonquantitative
6 treatment limitation, in operation, for medical and
7 surgical benefits; and

8 (E) disclose the specific findings and conclusions
9 reached by the insurer that the results of the
10 analyses described in subparagraphs (C) and (D)
11 indicate that the insurer is in compliance with this
12 Section and the Mental Health Parity and Addiction
13 Equity Act of 2008 and its implementing regulations,
14 which includes 42 CFR Parts 438, 440, and 457 and 45
15 CFR 146.136 and any other related federal regulations
16 found in the Code of Federal Regulations.

17 (7) Any other information necessary to clarify data
18 provided in accordance with this Section requested by the
19 Director, including information that may be proprietary or
20 have commercial value, under the requirements of Section
21 30 of the Viatical Settlements Act of 2009.

22 (1) An insurer that amends, delivers, issues, or renews a
23 group or individual policy of accident and health insurance or
24 a qualified health plan offered through the health insurance
25 marketplace in this State providing coverage for hospital or
26 medical treatment and for the treatment of mental, emotional,

1 nervous, or substance use disorders or conditions on or after
2 January 1, 2019 (the effective date of Public Act 100-1024)
3 shall, in advance of the plan year, make available to the
4 Department or, with respect to medical assistance, the
5 Department of Healthcare and Family Services and to all plan
6 participants and beneficiaries the information required in
7 subparagraphs (C) through (E) of paragraph (6) of subsection
8 (k). For plan participants and medical assistance
9 beneficiaries, the information required in subparagraphs (C)
10 through (E) of paragraph (6) of subsection (k) shall be made
11 available on a publicly available website whose web address is
12 prominently displayed in plan and managed care organization
13 informational and marketing materials.

14 (m) In conjunction with its compliance examination program
15 conducted in accordance with the Illinois State Auditing Act,
16 the Auditor General shall undertake a review of compliance by
17 the Department and the Department of Healthcare and Family
18 Services with Section 370c and this Section. Any findings
19 resulting from the review conducted under this Section shall
20 be included in the applicable State agency's compliance
21 examination report. Each compliance examination report shall
22 be issued in accordance with Section 3-14 of the Illinois
23 State Auditing Act. A copy of each report shall also be
24 delivered to the head of the applicable State agency and
25 posted on the Auditor General's website.

26 (Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21;

1 102-813, eff. 5-13-22; 103-94, eff. 1-1-24; 103-105, eff.
2 6-27-23; 103-605, eff. 7-1-24.)

3 (215 ILCS 5/1563)

4 Sec. 1563. Fees. The fees required by this Article are as
5 follows:

6 (1) Public adjuster license fee of \$250 for a person
7 who is a resident of Illinois and \$500 for a person who is
8 not a resident of Illinois, payable once every 2 years.

9 (2) Business entity license fee of \$250, payable once
10 every 2 years.

11 (3) Application fee of \$50 for processing each request
12 to take the written examination for a public adjuster
13 license.

14 (Source: P.A. 100-863, eff. 8-14-18.)

15 Section 10. The Dental Care Patient Protection Act is
16 amended by changing Section 75 as follows:

17 (215 ILCS 109/75)

18 Sec. 75. Application of other law.

19 (a) All provisions of this Act and other applicable law
20 that are not in conflict with this Act shall apply to managed
21 care dental plans and other persons subject to this Act. To the
22 extent that any provision of this Act or rule under this Act
23 would prevent the application of any standard or requirement

1 under the Network Adequacy and Transparency Act to a plan that
2 is subject to both statutes, the Network Adequacy and
3 Transparency Act shall supersede this Act.

4 (b) Solicitation of enrollees by a managed care entity
5 granted a certificate of authority or its representatives
6 shall not be construed to violate any provision of law
7 relating to solicitation or advertising by health
8 professionals.

9 (Source: P.A. 91-355, eff. 1-1-00.)

10 Section 15. The Network Adequacy and Transparency Act is
11 amended by changing Sections 5, 10, and 25 as follows:

12 (215 ILCS 124/5)

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

14 Sec. 5. Definitions. In this Act:

15 "Authorized representative" means a person to whom a
16 beneficiary has given express written consent to represent the
17 beneficiary; a person authorized by law to provide substituted
18 consent for a beneficiary; or the beneficiary's treating
19 provider only when the beneficiary or his or her family member
20 is unable to provide consent.

21 "Beneficiary" means an individual, an enrollee, an
22 insured, a participant, or any other person entitled to
23 reimbursement for covered expenses of or the discounting of
24 provider fees for health care services under a program in

1 which the beneficiary has an incentive to utilize the services
2 of a provider that has entered into an agreement or
3 arrangement with an issuer.

4 "Department" means the Department of Insurance.

5 "Essential community provider" has the meaning ascribed to
6 that term in 45 CFR 156.235.

7 "Excepted benefits" has the meaning ascribed to that term
8 in 42 U.S.C. 300gg-91(c) and implementing regulations.

9 "Excepted benefits" includes individual, group, or blanket
10 coverage.

11 "Exchange" has the meaning ascribed to that term in 45 CFR
12 155.20.

13 "Director" means the Director of Insurance.

14 "Family caregiver" means a relative, partner, friend, or
15 neighbor who has a significant relationship with the patient
16 and administers or assists the patient with activities of
17 daily living, instrumental activities of daily living, or
18 other medical or nursing tasks for the quality and welfare of
19 that patient.

20 "Group health plan" has the meaning ascribed to that term
21 in Section 5 of the Illinois Health Insurance Portability and
22 Accountability Act.

23 "Health insurance coverage" has the meaning ascribed to
24 that term in Section 5 of the Illinois Health Insurance
25 Portability and Accountability Act. "Health insurance
26 coverage" does not include any coverage or benefits under

1 Medicare or under the medical assistance program established
2 under Article V of the Illinois Public Aid Code.

3 "Issuer" means a "health insurance issuer" as defined in
4 Section 5 of the Illinois Health Insurance Portability and
5 Accountability Act.

6 "Material change" means a significant reduction in the
7 number of providers available in a network plan, including,
8 but not limited to, a reduction of 10% or more in a specific
9 type of providers within any county, the removal of a major
10 health system that causes a network to be significantly
11 different within any county from the network when the
12 beneficiary purchased the network plan, or any change that
13 would cause the network to no longer satisfy the requirements
14 of this Act or the Department's rules for network adequacy and
15 transparency.

16 "Network" means the group or groups of preferred providers
17 providing services to a network plan.

18 "Network plan" means an individual or group policy of
19 health insurance coverage that either requires a covered
20 person to use or creates incentives, including financial
21 incentives, for a covered person to use providers managed,
22 owned, under contract with, or employed by the issuer or by a
23 third party contracted to arrange, contract for, or administer
24 such provider-related incentives for the issuer.

25 "Ongoing course of treatment" means (1) treatment for a
26 life-threatening condition, which is a disease or condition

1 for which likelihood of death is probable unless the course of
2 the disease or condition is interrupted; (2) treatment for a
3 serious acute condition, defined as a disease or condition
4 requiring complex ongoing care that the covered person is
5 currently receiving, such as chemotherapy, radiation therapy,
6 post-operative visits, or a serious and complex condition as
7 defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of
8 treatment for a health condition that a treating provider
9 attests that discontinuing care by that provider would worsen
10 the condition or interfere with anticipated outcomes; (4) the
11 third trimester of pregnancy through the post-partum period;
12 (5) undergoing a course of institutional or inpatient care
13 from the provider within the meaning of 42 U.S.C.
14 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective
15 surgery from the provider, including receipt of preoperative
16 or postoperative care from such provider with respect to such
17 a surgery; (7) being determined to be terminally ill, as
18 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving
19 treatment for such illness from such provider; or (8) any
20 other treatment of a condition or disease that requires
21 repeated health care services pursuant to a plan of treatment
22 by a provider because of the potential for changes in the
23 therapeutic regimen or because of the potential for a
24 recurrence of symptoms.

25 "Preferred provider" means any provider who has entered,
26 either directly or indirectly, into an agreement with an

1 employer or risk-bearing entity relating to health care
2 services that may be rendered to beneficiaries under a network
3 plan.

4 "Providers" means physicians licensed to practice medicine
5 in all its branches, other health care professionals,
6 hospitals, or other health care institutions or facilities
7 that provide health care services.

8 ~~"Short term, limited duration insurance" means any type of~~
9 ~~accident and health insurance offered or provided within this~~
10 ~~State pursuant to a group or individual policy or individual~~
11 ~~certificate by a company, regardless of the situs state of the~~
12 ~~delivery of the policy, that has an expiration date specified~~
13 ~~in the contract that is fewer than 365 days after the original~~
14 ~~effective date. Regardless of the duration of coverage,~~
15 ~~"short term, limited duration insurance" does not include~~
16 ~~excepted benefits or any student health insurance coverage.~~

17 "Stand-alone dental plan" has the meaning ascribed to that
18 term in 45 CFR 156.400.

19 "Telehealth" has the meaning given to that term in Section
20 356z.22 of the Illinois Insurance Code.

21 "Telemedicine" has the meaning given to that term in
22 Section 49.5 of the Medical Practice Act of 1987.

23 "Tiered network" means a network that identifies and
24 groups some or all types of provider and facilities into
25 specific groups to which different provider reimbursement,
26 covered person cost-sharing or provider access requirements,

1 or any combination thereof, apply for the same services.

2 "Woman's principal health care provider" means a physician
3 licensed to practice medicine in all of its branches
4 specializing in obstetrics, gynecology, or family practice.

5 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
6 103-650, eff. 1-1-25.)

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

8 Sec. 5. Definitions. In this Act:

9 "Authorized representative" means a person to whom a
10 beneficiary has given express written consent to represent the
11 beneficiary; a person authorized by law to provide substituted
12 consent for a beneficiary; or the beneficiary's treating
13 provider only when the beneficiary or his or her family member
14 is unable to provide consent.

15 "Beneficiary" means an individual, an enrollee, an
16 insured, a participant, or any other person entitled to
17 reimbursement for covered expenses of or the discounting of
18 provider fees for health care services under a program in
19 which the beneficiary has an incentive to utilize the services
20 of a provider that has entered into an agreement or
21 arrangement with an issuer ~~insurer~~.

22 "Department" means the Department of Insurance.

23 "Director" means the Director of Insurance.

24 "Family caregiver" means a relative, partner, friend, or
25 neighbor who has a significant relationship with the patient

1 and administers or assists the patient with activities of
2 daily living, instrumental activities of daily living, or
3 other medical or nursing tasks for the quality and welfare of
4 that patient.

5 "Issuer" means a "health insurance issuer" as defined in
6 Section 5 of the Illinois Health Insurance Portability and
7 Accountability Act. ~~"Insurer" means any entity that offers~~
8 ~~individual or group accident and health insurance, including,~~
9 ~~but not limited to, health maintenance organizations,~~
10 ~~preferred provider organizations, exclusive provider~~
11 ~~organizations, and other plan structures requiring network~~
12 ~~participation, excluding the medical assistance program under~~
13 ~~the Illinois Public Aid Code, the State employees group health~~
14 ~~insurance program, workers compensation insurance, and~~
15 ~~pharmacy benefit managers.~~

16 "Material change" means a significant reduction in the
17 number of providers available in a network plan, including,
18 but not limited to, a reduction of 10% or more in a specific
19 type of providers, the removal of a major health system that
20 causes a network to be significantly different from the
21 network when the beneficiary purchased the network plan, or
22 any change that would cause the network to no longer satisfy
23 the requirements of this Act or the Department's rules for
24 network adequacy and transparency.

25 "Network" means the group or groups of preferred providers
26 providing services to a network plan.

1 "Network plan" means an individual or group policy of
2 accident and health insurance that either requires a covered
3 person to use or creates incentives, including financial
4 incentives, for a covered person to use providers managed,
5 owned, under contract with, or employed by the issuer ~~insurer~~.

6 "Ongoing course of treatment" means (1) treatment for a
7 life-threatening condition, which is a disease or condition
8 for which likelihood of death is probable unless the course of
9 the disease or condition is interrupted; (2) treatment for a
10 serious acute condition, defined as a disease or condition
11 requiring complex ongoing care that the covered person is
12 currently receiving, such as chemotherapy, radiation therapy,
13 or post-operative visits; (3) a course of treatment for a
14 health condition that a treating provider attests that
15 discontinuing care by that provider would worsen the condition
16 or interfere with anticipated outcomes; or (4) the third
17 trimester of pregnancy through the post-partum period.

18 "Preferred provider" means any provider who has entered,
19 either directly or indirectly, into an agreement with an
20 employer or risk-bearing entity relating to health care
21 services that may be rendered to beneficiaries under a network
22 plan.

23 "Providers" means physicians licensed to practice medicine
24 in all its branches, other health care professionals,
25 hospitals, or other health care institutions that provide
26 health care services.

1 "Telehealth" has the meaning given to that term in Section
2 356z.22 of the Illinois Insurance Code.

3 "Telemedicine" has the meaning given to that term in
4 Section 49.5 of the Medical Practice Act of 1987.

5 "Tiered network" means a network that identifies and
6 groups some or all types of provider and facilities into
7 specific groups to which different provider reimbursement,
8 covered person cost-sharing or provider access requirements,
9 or any combination thereof, apply for the same services.

10 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
11 103-718, eff. 7-19-24.)

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

13 Sec. 5. Definitions. In this Act:

14 "Authorized representative" means a person to whom a
15 beneficiary has given express written consent to represent the
16 beneficiary; a person authorized by law to provide substituted
17 consent for a beneficiary; or the beneficiary's treating
18 provider only when the beneficiary or his or her family member
19 is unable to provide consent.

20 "Beneficiary" means an individual, an enrollee, an
21 insured, a participant, or any other person entitled to
22 reimbursement for covered expenses of or the discounting of
23 provider fees for health care services under a program in
24 which the beneficiary has an incentive to utilize the services
25 of a provider that has entered into an agreement or

1 arrangement with an issuer ~~insurer~~.

2 "Department" means the Department of Insurance.

3 "Director" means the Director of Insurance.

4 "Excepted benefits" has the meaning given to that term in
5 42 U.S.C. 300gg-91(c).

6 "Family caregiver" means a relative, partner, friend, or
7 neighbor who has a significant relationship with the patient
8 and administers or assists the patient with activities of
9 daily living, instrumental activities of daily living, or
10 other medical or nursing tasks for the quality and welfare of
11 that patient.

12 "Issuer" means a "health insurance issuer" as defined in
13 Section 5 of the Illinois Health Insurance Portability and
14 Accountability Act. ~~"Insurer" means any entity that offers~~
15 ~~individual or group accident and health insurance, including,~~
16 ~~but not limited to, health maintenance organizations,~~
17 ~~preferred provider organizations, exclusive provider~~
18 ~~organizations, and other plan structures requiring network~~
19 ~~participation, excluding the medical assistance program under~~
20 ~~the Illinois Public Aid Code, the State employees group health~~
21 ~~insurance program, workers compensation insurance, and~~
22 ~~pharmacy benefit managers.~~

23 "Material change" means a significant reduction in the
24 number of providers available in a network plan, including,
25 but not limited to, a reduction of 10% or more in a specific
26 type of providers, the removal of a major health system that

1 causes a network to be significantly different from the
2 network when the beneficiary purchased the network plan, or
3 any change that would cause the network to no longer satisfy
4 the requirements of this Act or the Department's rules for
5 network adequacy and transparency.

6 "Network" means the group or groups of preferred providers
7 providing services to a network plan.

8 "Network plan" means an individual or group policy of
9 accident and health insurance that either requires a covered
10 person to use or creates incentives, including financial
11 incentives, for a covered person to use providers managed,
12 owned, under contract with, or employed by the issuer ~~insurer~~.

13 "Ongoing course of treatment" means (1) treatment for a
14 life-threatening condition, which is a disease or condition
15 for which likelihood of death is probable unless the course of
16 the disease or condition is interrupted; (2) treatment for a
17 serious acute condition, defined as a disease or condition
18 requiring complex ongoing care that the covered person is
19 currently receiving, such as chemotherapy, radiation therapy,
20 or post-operative visits; (3) a course of treatment for a
21 health condition that a treating provider attests that
22 discontinuing care by that provider would worsen the condition
23 or interfere with anticipated outcomes; or (4) the third
24 trimester of pregnancy through the post-partum period.

25 "Preferred provider" means any provider who has entered,
26 either directly or indirectly, into an agreement with an

1 employer or risk-bearing entity relating to health care
2 services that may be rendered to beneficiaries under a network
3 plan.

4 "Providers" means physicians licensed to practice medicine
5 in all its branches, other health care professionals,
6 hospitals, or other health care institutions that provide
7 health care services.

8 ~~"Short term, limited duration health insurance coverage~~
9 ~~has the meaning given to that term in Section 5 of the~~
10 ~~Short Term, Limited Duration Health Insurance Coverage Act.~~

11 "Stand-alone dental plan" has the meaning given to that
12 term in 45 CFR 156.400.

13 "Telehealth" has the meaning given to that term in Section
14 356z.22 of the Illinois Insurance Code.

15 "Telemedicine" has the meaning given to that term in
16 Section 49.5 of the Medical Practice Act of 1987.

17 "Tiered network" means a network that identifies and
18 groups some or all types of provider and facilities into
19 specific groups to which different provider reimbursement,
20 covered person cost-sharing or provider access requirements,
21 or any combination thereof, apply for the same services.

22 "Woman's principal health care provider" means a physician
23 licensed to practice medicine in all of its branches
24 specializing in obstetrics, gynecology, or family practice.

25 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
26 103-777, eff. 1-1-25.)

1 (215 ILCS 124/10)

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

3 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 physicians and facility-based physicians when
2 applicable under the contract, necessary to meet the
3 health care needs and service demands of the currently
4 enrolled population;

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

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

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

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

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

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

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

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

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

15 (1) The minimum ratio of physicians or other providers
16 to plan beneficiaries shall be established by the
17 Department in consultation with the Department of Public
18 Health based upon the guidance from the federal Centers
19 for Medicare and Medicaid Services. The Department shall
20 not establish ratios for vision or dental providers who
21 provide services under dental-specific or vision-specific
22 benefits, except to the extent provided under federal law
23 for stand-alone dental plans. The Department shall
24 consider establishing ratios for the following physicians
25 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 (2) The Director shall establish a process for the
4 review of the adequacy of these standards, along with an
5 assessment of additional specialties to be included in the
6 list under this subsection (c).

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

23 (d) The network plan shall demonstrate to the Director
24 maximum travel and distance standards and appointment wait
25 time standards for plan beneficiaries, which shall be
26 established by the Department in consultation with the

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

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

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

14 Notwithstanding any other law or Department rule, the
15 maximum travel time and distance standards and appointment
16 wait time standards shall be no greater than any such
17 standards 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 if
20 the network plan is issued in the large group market or is
21 otherwise not issued through an exchange. Federal standards
22 for stand-alone dental plans shall only apply to such network
23 plans. In the absence of an applicable Department rule, the
24 federal standards shall apply for the time period specified in
25 the federal law, regulation, or guidance. If the Centers for
26 Medicare and Medicaid Services establish standards that are

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 beneficiaries currently seek this type of care or where
2 the physicians currently refer beneficiaries, or both; or

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

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

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

1 and reimburse beneficiaries to achieve that objective if their
2 claims were processed at the out-of-network level contrary to
3 this subsection. Nothing in this subsection shall be construed
4 to supersede Section 356z.3a of the Illinois Insurance Code.

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

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

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

1 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

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

3 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 for each county type, such as large counties, metro counties,
2 or rural counties as defined by Department rule.

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

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

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

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

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

1 appointment outside of these required time frames.

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

24 (2) For beneficiaries residing in all Illinois counties,
25 network adequacy standards for timely and proximate access to
26 treatment for mental, emotional, nervous, or substance use

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

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

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

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

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

1 federal law ~~by the Department~~ may request an exception to
2 these requirements from the Department. The Department may
3 grant an exception in the following circumstances:

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

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

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

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

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

4 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
5 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

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

7 Sec. 10. Network adequacy.

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

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

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

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

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

1 beneficiaries within the utilization review, grievance, or
2 appeals processes established by the issuer ~~insurer~~ in
3 accordance with any rights or remedies available under
4 applicable State or federal law.

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

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

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

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

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

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

26 (A) the type of health care services to be

1 provided by the network plan;

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

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

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

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

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

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

1 preferred provider. This provision shall be consistent
2 with Section 356z.3a of the Illinois Insurance Code.

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

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

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

20 (A) Primary Care;

21 (B) Pediatrics;

22 (C) Cardiology;

23 (D) Gastroenterology;

24 (E) General Surgery;

25 (F) Neurology;

26 (G) OB/GYN;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (f) The network plan may consider use of other health care
26 service delivery options, such as telemedicine or telehealth,

1 mobile clinics, and centers of excellence, or other ways of
2 delivering care to partially meet the requirements set under
3 this Section.

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

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

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

1 both; or

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

4 (h) Issuers ~~Insurers~~ are required to report to the
5 Director any material change to an approved network plan
6 within 15 days after the change occurs and any change that
7 would result in failure to meet the requirements of this Act.
8 Upon notice from the issuer ~~insurer~~, the Director shall
9 reevaluate the network plan's compliance with the network
10 adequacy and transparency 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; 103-718, eff. 7-19-24.)

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

14 Sec. 10. Network adequacy.

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

11 (b) Issuers ~~Insurers~~ must file for review a description of
12 the services to be offered through a network plan. The
13 description 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 issuer ~~insurer~~
25 does not 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 issuer ~~insurer~~ shall
5 ensure, directly or indirectly, by terms contained in the
6 payer 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, except to the extent provided under federal law
25 for stand-alone dental plans. The Department shall
26 consider establishing ratios for the following physicians

1 or other providers:

2 (A) Primary Care;

3 (B) Pediatrics;

4 (C) Cardiology;

5 (D) Gastroenterology;

6 (E) General Surgery;

7 (F) Neurology;

8 (G) OB/GYN;

9 (H) Oncology/Radiation;

10 (I) Ophthalmology;

11 (J) Urology;

12 (K) Behavioral Health;

13 (L) Allergy/Immunology;

14 (M) Chiropractic;

15 (N) Dermatology;

16 (O) Endocrinology;

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

18 (Q) Infectious Disease;

19 (R) Nephrology;

20 (S) Neurosurgery;

21 (T) Orthopedic Surgery;

22 (U) Physiatry/Rehabilitative;

23 (V) Plastic Surgery;

24 (W) Pulmonary;

25 (X) Rheumatology;

26 (Y) Anesthesiology;

- 1 (Z) Pain Medicine;
- 2 (AA) Pediatric Specialty Services;
- 3 (BB) Outpatient Dialysis; and
- 4 (CC) HIV.

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

9 (3) If the federal Centers for Medicare and Medicaid
10 Services establishes minimum provider ratios for
11 stand-alone dental plans in the type of exchange in use in
12 this State for a given plan year, the Department shall
13 enforce those standards for stand-alone dental plans for
14 that plan year.

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

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

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

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

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

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

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

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

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

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

1 subsection (d-5) for qualified health plans for that plan
2 year.

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

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

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

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

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

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

11 (h) Issuers ~~Insurers~~ are required to report to the
12 Director any material change to an approved network plan
13 within 15 days after the change occurs and any change that
14 would result in failure to meet the requirements of this Act.
15 Upon notice from the insurer, the Director shall reevaluate
16 the network plan's compliance with the network adequacy and
17 transparency 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; 103-777, eff. 1-1-25.)

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

21 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

1 the network plan.

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

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

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

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

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

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

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

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

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

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

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

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

24 (1) The ratio of physicians or other providers to plan
25 beneficiaries shall be established annually by the
26 Department in consultation with the Department of Public

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

7 (A) Primary Care;

8 (B) Pediatrics;

9 (C) Cardiology;

10 (D) Gastroenterology;

11 (E) General Surgery;

12 (F) Neurology;

13 (G) OB/GYN;

14 (H) Oncology/Radiation;

15 (I) Ophthalmology;

16 (J) Urology;

17 (K) Behavioral Health;

18 (L) Allergy/Immunology;

19 (M) Chiropractic;

20 (N) Dermatology;

21 (O) Endocrinology;

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

23 (Q) Infectious Disease;

24 (R) Nephrology;

25 (S) Neurosurgery;

26 (T) Orthopedic Surgery;

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

10 (1.5) Beginning January 1, 2026, every issuer ~~insurer~~
11 shall demonstrate to the Director that each in-network
12 hospital has at least one radiologist, pathologist,
13 anesthesiologist, and emergency room physician as a
14 preferred provider in a network plan. The Department may,
15 by rule, require additional types of hospital-based
16 medical specialists to be included as preferred providers
17 in each in-network hospital in a network plan.

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

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

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

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

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

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

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

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

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

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

26 (2) For beneficiaries residing in all Illinois counties,

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

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

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

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

25 (g) Except for the requirements set forth in subsection
26 (d-5), issuers ~~insurers~~ who are not able to comply with the

1 provider ratios, ~~and~~ time and distance standards, and
2 appointment wait-time standards established under this Act or
3 federal law ~~by the Department~~ may request an exception to
4 these requirements from the Department. The Department may
5 grant an exception in the following circumstances:

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

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

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

25 (h) Issuers ~~Insurers~~ are required to report to the
26 Director any material change to an approved network plan

1 within 15 days after the change occurs and any change that
2 would result in failure to meet the requirements of this Act.
3 Upon notice from the issuer ~~insurer~~, the Director shall
4 reevaluate the network plan's compliance with the network
5 adequacy and transparency standards of this Act.

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

8 (215 ILCS 124/25)

9 (Text of Section from P.A. 103-605)

10 Sec. 25. Network transparency.

11 (a) A network plan shall post electronically an
12 up-to-date, accurate, and complete provider directory for each
13 of its network plans, with the information and search
14 functions, as described in this Section.

15 (1) In making the directory available electronically,
16 the network plans shall ensure that the general public is
17 able to view all of the current providers for a plan
18 through a clearly identifiable link or tab and without
19 creating or accessing an account or entering a policy or
20 contract number.

21 (2) The network plan shall update the online provider
22 directory at least monthly. Providers shall notify the
23 network plan electronically or in writing of any changes
24 to their information as listed in the provider directory,
25 including the information required in subparagraph (K) of

1 paragraph (1) of subsection (b). The network plan shall
2 update its online provider directory in a manner
3 consistent with the information provided by the provider
4 within 10 business days after being notified of the change
5 by the provider. Nothing in this paragraph (2) shall void
6 any contractual relationship between the provider and the
7 plan.

8 (3) The network plan shall audit periodically at least
9 25% of its provider directories for accuracy, make any
10 corrections necessary, and retain documentation of the
11 audit. The network plan shall submit the audit to the
12 Director upon request. As part of these audits, the
13 network plan shall contact any provider in its network
14 that has not submitted a claim to the plan or otherwise
15 communicated his or her intent to continue participation
16 in the plan's network.

17 (4) A network plan shall provide a printed copy of a
18 current provider directory or a printed copy of the
19 requested directory information upon request of a
20 beneficiary or a prospective beneficiary. Printed copies
21 must be updated quarterly and an errata that reflects
22 changes in the provider network must be updated quarterly.

23 (5) For each network plan, a network plan shall
24 include, in plain language in both the electronic and
25 print directory, the following general information:

26 (A) in plain language, a description of the

1 criteria the plan has used to build its provider
2 network;

3 (B) if applicable, in plain language, a
4 description of the criteria the issuer ~~insurer~~ or
5 network plan has used to create tiered networks;

6 (C) if applicable, in plain language, how the
7 network plan designates the different provider tiers
8 or levels in the network and identifies for each
9 specific provider, hospital, or other type of facility
10 in the network which tier each is placed, for example,
11 by name, symbols, or grouping, in order for a
12 beneficiary-covered person or a prospective
13 beneficiary-covered person to be able to identify the
14 provider tier; and

15 (D) if applicable, a notation that authorization
16 or referral may be required to access some providers.

17 (6) A network plan shall make it clear for both its
18 electronic and print directories what provider directory
19 applies to which network plan, such as including the
20 specific name of the network plan as marketed and issued
21 in this State. The network plan shall include in both its
22 electronic and print directories a customer service email
23 address and telephone number or electronic link that
24 beneficiaries or the general public may use to notify the
25 network plan of inaccurate provider directory information
26 and contact information for the Department's Office of

1 Consumer Health Insurance.

2 (7) A provider directory, whether in electronic or
3 print format, shall accommodate the communication needs of
4 individuals with disabilities, and include a link to or
5 information regarding available assistance for persons
6 with limited English proficiency.

7 (b) For each network plan, a network plan shall make
8 available through an electronic provider directory the
9 following information in a searchable format:

10 (1) for health care professionals:

11 (A) name;

12 (B) gender;

13 (C) participating office locations;

14 (D) specialty, if applicable;

15 (E) medical group affiliations, if applicable;

16 (F) facility affiliations, if applicable;

17 (G) participating facility affiliations, if
18 applicable;

19 (H) languages spoken other than English, if
20 applicable;

21 (I) whether accepting new patients;

22 (J) board certifications, if applicable; and

23 (K) use of telehealth or telemedicine, including,
24 but not limited to:

25 (i) whether the provider offers the use of
26 telehealth or telemedicine to deliver services to

1 patients for whom it would be clinically
2 appropriate;

3 (ii) what modalities are used and what types
4 of services may be provided via telehealth or
5 telemedicine; and

6 (iii) whether the provider has the ability and
7 willingness to include in a telehealth or
8 telemedicine encounter a family caregiver who is
9 in a separate location than the patient if the
10 patient wishes and provides his or her consent;

11 (2) for hospitals:

12 (A) hospital name;

13 (B) hospital type (such as acute, rehabilitation,
14 children's, or cancer);

15 (C) participating hospital location; and

16 (D) hospital accreditation status; and

17 (3) for facilities, other than hospitals, by type:

18 (A) facility name;

19 (B) facility type;

20 (C) types of services performed; and

21 (D) participating facility location or locations.

22 (c) For the electronic provider directories, for each
23 network plan, a network plan shall make available all of the
24 following information in addition to the searchable
25 information required in this Section:

26 (1) for health care professionals:

- 1 (A) contact information; and
2 (B) languages spoken other than English by
3 clinical staff, if applicable;
4 (2) for hospitals, telephone number; and
5 (3) for facilities other than hospitals, telephone
6 number.

7 (d) The issuer ~~insurer~~ or network plan shall make
8 available in print, upon request, the following provider
9 directory information for the applicable network plan:

10 (1) for health care professionals:

11 (A) name;

12 (B) contact information;

13 (C) participating office location or locations;

14 (D) specialty, if applicable;

15 (E) languages spoken other than English, if
16 applicable;

17 (F) whether accepting new patients; and

18 (G) use of telehealth or telemedicine, including,
19 but not limited to:

20 (i) whether the provider offers the use of
21 telehealth or telemedicine to deliver services to
22 patients for whom it would be clinically
23 appropriate;

24 (ii) what modalities are used and what types
25 of services may be provided via telehealth or
26 telemedicine; and

1 (iii) whether the provider has the ability and
2 willingness to include in a telehealth or
3 telemedicine encounter a family caregiver who is
4 in a separate location than the patient if the
5 patient wishes and provides his or her consent;

6 (2) for hospitals:

7 (A) hospital name;

8 (B) hospital type (such as acute, rehabilitation,
9 children's, or cancer); and

10 (C) participating hospital location and telephone
11 number; and

12 (3) for facilities, other than hospitals, by type:

13 (A) facility name;

14 (B) facility type;

15 (C) types of services performed; and

16 (D) participating facility location or locations
17 and telephone numbers.

18 (e) The network plan shall include a disclosure in the
19 print format provider directory that the information included
20 in the directory is accurate as of the date of printing and
21 that beneficiaries or prospective beneficiaries should consult
22 the issuer's ~~insurer's~~ electronic provider directory on its
23 website and contact the provider. The network plan shall also
24 include a telephone number in the print format provider
25 directory for a customer service representative where the
26 beneficiary can obtain current provider directory information.

1 (f) The Director may conduct periodic audits of the
2 accuracy of provider directories. A network plan shall not be
3 subject to any fines or penalties for information required in
4 this Section that a provider submits that is inaccurate or
5 incomplete.

6 (Source: P.A. 102-92, eff. 7-9-21; 103-605, eff. 7-1-24.)

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

8 Sec. 25. Network transparency.

9 (a) A network plan shall post electronically an
10 up-to-date, accurate, and complete provider directory for each
11 of its network plans, with the information and search
12 functions, as described in this Section.

13 (1) In making the directory available electronically,
14 the network plans shall ensure that the general public is
15 able to view all of the current providers for a plan
16 through a clearly identifiable link or tab and without
17 creating or accessing an account or entering a policy or
18 contract number.

19 (2) An issuer's failure to update a network plan's
20 directory shall subject the issuer to a civil penalty of
21 \$5,000 per month. Providers shall notify the network plan
22 electronically or in writing within 10 business days of
23 any changes to their information as listed in the provider
24 directory, including the information required in
25 subsections (b), (c), and (d). With regard to subparagraph

1 (I) of paragraph (1) of subsection (b), the provider must
2 give notice to the issuer within 20 business days of
3 deciding to cease accepting new patients covered by the
4 plan if the new patient limitation is expected to last 40
5 business days or longer. The network plan shall update its
6 online provider directory in a manner consistent with the
7 information provided by the provider within 2 business
8 days after being notified of the change by the provider.
9 Nothing in this paragraph (2) shall void any contractual
10 relationship between the provider and the plan.

11 (3) At least once every 90 days, the issuer shall
12 self-audit each network plan's provider directories for
13 accuracy, make any corrections necessary, and retain
14 documentation of the audit. The issuer shall submit the
15 self-audit and a summary to the Department, and the
16 Department shall make the summary of each self-audit
17 publicly available. The Department shall specify the
18 requirements of the summary, which shall be statistical in
19 nature except for a high-level narrative evaluating the
20 impact of internal and external factors on the accuracy of
21 the directory and the timeliness of updates. As part of
22 these self-audits, the network plan shall contact any
23 provider in its network that has not submitted a claim to
24 the plan or otherwise communicated his or her intent to
25 continue participation in the plan's network. The
26 self-audits shall comply with 42 U.S.C. 300gg-115(a)(2),

1 except that "provider directory information" shall include
2 all information required to be included in a provider
3 directory pursuant to this Act.

4 (4) A network plan shall provide a print copy of a
5 current provider directory or a print copy of the
6 requested directory information upon request of a
7 beneficiary or a prospective beneficiary. Except when an
8 issuer's print copies use the same provider information as
9 the electronic provider directory on each print copy's
10 date of printing, print copies must be updated at least
11 every 90 days and errata that reflects changes in the
12 provider network must be included in each update.

13 (5) For each network plan, a network plan shall
14 include, in plain language in both the electronic and
15 print directory, the following general information:

16 (A) in plain language, a description of the
17 criteria the plan has used to build its provider
18 network;

19 (B) if applicable, in plain language, a
20 description of the criteria the issuer or network plan
21 has used to create tiered networks;

22 (C) if applicable, in plain language, how the
23 network plan designates the different provider tiers
24 or levels in the network and identifies for each
25 specific provider, hospital, or other type of facility
26 in the network which tier each is placed, for example,

1 by name, symbols, or grouping, in order for a
2 beneficiary-covered person or a prospective
3 beneficiary-covered person to be able to identify the
4 provider tier;

5 (D) if applicable, a notation that authorization
6 or referral may be required to access some providers;

7 (E) a telephone number and email address for a
8 customer service representative to whom directory
9 inaccuracies may be reported; and

10 (F) a detailed description of the process to
11 dispute charges for out-of-network providers,
12 hospitals, or facilities that were incorrectly listed
13 as in-network prior to the provision of care and a
14 telephone number and email address to dispute such
15 charges.

16 (6) A network plan shall make it clear for both its
17 electronic and print directories what provider directory
18 applies to which network plan, such as including the
19 specific name of the network plan as marketed and issued
20 in this State. The network plan shall include in both its
21 electronic and print directories a customer service email
22 address and telephone number or electronic link that
23 beneficiaries or the general public may use to notify the
24 network plan of inaccurate provider directory information
25 and contact information for the Department's Office of
26 Consumer Health Insurance.

1 (7) A provider directory, whether in electronic or
2 print format, shall accommodate the communication needs of
3 individuals with disabilities, and include a link to or
4 information regarding available assistance for persons
5 with limited English proficiency.

6 (b) For each network plan, a network plan shall make
7 available through an electronic provider directory the
8 following information in a searchable format:

9 (1) for health care professionals:

10 (A) name;

11 (B) gender;

12 (C) participating office locations;

13 (D) patient population served (such as pediatric,
14 adult, elderly, or women) and specialty or
15 subspecialty, if applicable;

16 (E) medical group affiliations, if applicable;

17 (F) facility affiliations, if applicable;

18 (G) participating facility affiliations, if
19 applicable;

20 (H) languages spoken other than English, if
21 applicable;

22 (I) whether accepting new patients;

23 (J) board certifications, if applicable;

24 (K) use of telehealth or telemedicine, including,
25 but not limited to:

26 (i) whether the provider offers the use of

1 telehealth or telemedicine to deliver services to
2 patients for whom it would be clinically
3 appropriate;

4 (ii) what modalities are used and what types
5 of services may be provided via telehealth or
6 telemedicine; and

7 (iii) whether the provider has the ability and
8 willingness to include in a telehealth or
9 telemedicine encounter a family caregiver who is
10 in a separate location than the patient if the
11 patient wishes and provides his or her consent;

12 (L) whether the health care professional accepts
13 appointment requests from patients; and

14 (M) the anticipated date the provider will leave
15 the network, if applicable, which shall be included no
16 more than 10 days after the issuer confirms that the
17 provider is scheduled to leave the network;

18 (2) for hospitals:

19 (A) hospital name;

20 (B) hospital type (such as acute, rehabilitation,
21 children's, or cancer);

22 (C) participating hospital location;

23 (D) hospital accreditation status; and

24 (E) the anticipated date the hospital will leave
25 the network, if applicable, which shall be included no
26 more than 10 days after the issuer confirms the

- 1 hospital is scheduled to leave the network; and
- 2 (3) for facilities, other than hospitals, by type:
- 3 (A) facility name;
- 4 (B) facility type;
- 5 (C) types of services performed;
- 6 (D) participating facility location or locations;
- 7 and
- 8 (E) the anticipated date the facility will leave
- 9 the network, if applicable, which shall be included no
- 10 more than 10 days after the issuer confirms the
- 11 facility is scheduled to leave the network.
- 12 (c) For the electronic provider directories, for each
- 13 network plan, a network plan shall make available all of the
- 14 following information in addition to the searchable
- 15 information required in this Section:
- 16 (1) for health care professionals:
- 17 (A) contact information, including both a
- 18 telephone number and digital contact information if
- 19 the provider has supplied digital contact information;
- 20 and
- 21 (B) languages spoken other than English by
- 22 clinical staff, if applicable;
- 23 (2) for hospitals, telephone number and digital
- 24 contact information; and
- 25 (3) for facilities other than hospitals, telephone
- 26 number.

1 (d) The issuer or network plan shall make available in
2 print, upon request, the following provider directory
3 information for the applicable network plan:

4 (1) for health care professionals:

5 (A) name;

6 (B) contact information, including a telephone
7 number and digital contact information if the provider
8 has supplied digital contact information;

9 (C) participating office location or locations;

10 (D) patient population (such as pediatric, adult,
11 elderly, or women) and specialty or subspecialty, if
12 applicable;

13 (E) languages spoken other than English, if
14 applicable;

15 (F) whether accepting new patients;

16 (G) use of telehealth or telemedicine, including,
17 but not limited to:

18 (i) whether the provider offers the use of
19 telehealth or telemedicine to deliver services to
20 patients for whom it would be clinically
21 appropriate;

22 (ii) what modalities are used and what types
23 of services may be provided via telehealth or
24 telemedicine; and

25 (iii) whether the provider has the ability and
26 willingness to include in a telehealth or

1 telemedicine encounter a family caregiver who is
2 in a separate location than the patient if the
3 patient wishes and provides his or her consent;
4 and

5 (H) whether the health care professional accepts
6 appointment requests from patients.

7 (2) for hospitals:

8 (A) hospital name;

9 (B) hospital type (such as acute, rehabilitation,
10 children's, or cancer); and

11 (C) participating hospital location, telephone
12 number, and digital contact information; and

13 (3) for facilities, other than hospitals, by type:

14 (A) facility name;

15 (B) facility type;

16 (C) patient population (such as pediatric, adult,
17 elderly, or women) served, if applicable, and types of
18 services performed; and

19 (D) participating facility location or locations,
20 telephone numbers, and digital contact information for
21 each location.

22 (e) The network plan shall include a disclosure in the
23 print format provider directory that the information included
24 in the directory is accurate as of the date of printing and
25 that beneficiaries or prospective beneficiaries should consult
26 the issuer's electronic provider directory on its website and

1 contact the provider. The network plan shall also include a
2 telephone number and email address in the print format
3 provider directory for a customer service representative where
4 the beneficiary can obtain current provider directory
5 information or report provider directory inaccuracies. The
6 printed provider directory shall include a detailed
7 description of the process to dispute charges for
8 out-of-network providers, hospitals, or facilities that were
9 incorrectly listed as in-network prior to the provision of
10 care and a telephone number and email address to dispute those
11 charges.

12 (f) The Director may conduct periodic audits of the
13 accuracy of provider directories. A network plan shall not be
14 subject to any fines or penalties for information required in
15 this Section that a provider submits that is inaccurate or
16 incomplete.

17 (g) To the extent not otherwise provided in this Act, an
18 issuer shall comply with the requirements of 42 U.S.C.
19 300gg-115, except that "provider directory information" shall
20 include all information required to be included in a provider
21 directory pursuant to this Section.

22 (h) If the issuer or the Department identifies a provider
23 incorrectly listed in the provider directory, the issuer shall
24 check each of the issuer's network plan provider directories
25 for the provider within 2 business days to ascertain whether
26 the provider is a preferred provider in that network plan and,

1 if the provider is incorrectly listed in the provider
2 directory, remove the provider from the provider directory
3 without delay.

4 (i) If the Director determines that an issuer violated
5 this Section, the Director may assess a fine up to \$5,000 per
6 violation, except for inaccurate information given by a
7 provider to the issuer. If an issuer, or any entity or person
8 acting on the issuer's behalf, knew or reasonably should have
9 known that a provider was incorrectly included in a provider
10 directory, the Director may assess a fine of up to \$25,000 per
11 violation against the issuer.

12 (j) This Section applies to network plans not otherwise
13 exempt under Section 3, including stand-alone dental plans.

14 (Source: P.A. 102-92, eff. 7-9-21; 103-650, eff. 1-1-25.)

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

16 Sec. 25. Network transparency.

17 (a) A network plan shall post electronically an
18 up-to-date, accurate, and complete provider directory for each
19 of its network plans, with the information and search
20 functions, as described in this Section.

21 (1) In making the directory available electronically,
22 the network plans shall ensure that the general public is
23 able to view all of the current providers for a plan
24 through a clearly identifiable link or tab and without
25 creating or accessing an account or entering a policy or

1 contract number.

2 (2) The network plan shall update the online provider
3 directory at least monthly. Providers shall notify the
4 network plan electronically or in writing of any changes
5 to their information as listed in the provider directory,
6 including the information required in subparagraph (K) of
7 paragraph (1) of subsection (b). The network plan shall
8 update its online provider directory in a manner
9 consistent with the information provided by the provider
10 within 10 business days after being notified of the change
11 by the provider. Nothing in this paragraph (2) shall void
12 any contractual relationship between the provider and the
13 plan.

14 (3) The network plan shall audit periodically at least
15 25% of its provider directories for accuracy, make any
16 corrections necessary, and retain documentation of the
17 audit. The network plan shall submit the audit to the
18 Director upon request. As part of these audits, the
19 network plan shall contact any provider in its network
20 that has not submitted a claim to the plan or otherwise
21 communicated his or her intent to continue participation
22 in the plan's network.

23 (4) A network plan shall provide a printed copy of a
24 current provider directory or a printed copy of the
25 requested directory information upon request of a
26 beneficiary or a prospective beneficiary. Printed copies

1 must be updated quarterly and an errata that reflects
2 changes in the provider network must be updated quarterly.

3 (5) For each network plan, a network plan shall
4 include, in plain language in both the electronic and
5 print directory, the following general information:

6 (A) in plain language, a description of the
7 criteria the plan has used to build its provider
8 network;

9 (B) if applicable, in plain language, a
10 description of the criteria the issuer ~~insurer~~ or
11 network plan has used to create tiered networks;

12 (C) if applicable, in plain language, how the
13 network plan designates the different provider tiers
14 or levels in the network and identifies for each
15 specific provider, hospital, or other type of facility
16 in the network which tier each is placed, for example,
17 by name, symbols, or grouping, in order for a
18 beneficiary-covered person or a prospective
19 beneficiary-covered person to be able to identify the
20 provider tier; and

21 (D) if applicable, a notation that authorization
22 or referral may be required to access some providers.

23 (6) A network plan shall make it clear for both its
24 electronic and print directories what provider directory
25 applies to which network plan, such as including the
26 specific name of the network plan as marketed and issued

1 in this State. The network plan shall include in both its
2 electronic and print directories a customer service email
3 address and telephone number or electronic link that
4 beneficiaries or the general public may use to notify the
5 network plan of inaccurate provider directory information
6 and contact information for the Department's Office of
7 Consumer Health Insurance.

8 (7) A provider directory, whether in electronic or
9 print format, shall accommodate the communication needs of
10 individuals with disabilities, and include a link to or
11 information regarding available assistance for persons
12 with limited English proficiency.

13 (b) For each network plan, a network plan shall make
14 available through an electronic provider directory the
15 following information in a searchable format:

16 (1) for health care professionals:

17 (A) name;

18 (B) gender;

19 (C) participating office locations;

20 (D) specialty, if applicable;

21 (E) medical group affiliations, if applicable;

22 (F) facility affiliations, if applicable;

23 (G) participating facility affiliations, if
24 applicable;

25 (H) languages spoken other than English, if
26 applicable;

- 1 (I) whether accepting new patients;
- 2 (J) board certifications, if applicable; and
- 3 (K) use of telehealth or telemedicine, including,
- 4 but not limited to:
- 5 (i) whether the provider offers the use of
- 6 telehealth or telemedicine to deliver services to
- 7 patients for whom it would be clinically
- 8 appropriate;
- 9 (ii) what modalities are used and what types
- 10 of services may be provided via telehealth or
- 11 telemedicine; and
- 12 (iii) whether the provider has the ability and
- 13 willingness to include in a telehealth or
- 14 telemedicine encounter a family caregiver who is
- 15 in a separate location than the patient if the
- 16 patient wishes and provides his or her consent;
- 17 (2) for hospitals:
- 18 (A) hospital name;
- 19 (B) hospital type (such as acute, rehabilitation,
- 20 children's, or cancer);
- 21 (C) participating hospital location; and
- 22 (D) hospital accreditation status; and
- 23 (3) for facilities, other than hospitals, by type:
- 24 (A) facility name;
- 25 (B) facility type;
- 26 (C) types of services performed; and

1 (D) participating facility location or locations.

2 (c) For the electronic provider directories, for each
3 network plan, a network plan shall make available all of the
4 following information in addition to the searchable
5 information required in this Section:

6 (1) for health care professionals:

7 (A) contact information; and

8 (B) languages spoken other than English by
9 clinical staff, if applicable;

10 (2) for hospitals, telephone number; and

11 (3) for facilities other than hospitals, telephone
12 number.

13 (d) The issuer ~~insurer~~ or network plan shall make
14 available in print, upon request, the following provider
15 directory information for the applicable network plan:

16 (1) for health care professionals:

17 (A) name;

18 (B) contact information;

19 (C) participating office location or locations;

20 (D) specialty, if applicable;

21 (E) languages spoken other than English, if
22 applicable;

23 (F) whether accepting new patients; and

24 (G) use of telehealth or telemedicine, including,
25 but not limited to:

26 (i) whether the provider offers the use of

1 telehealth or telemedicine to deliver services to
2 patients for whom it would be clinically
3 appropriate;

4 (ii) what modalities are used and what types
5 of services may be provided via telehealth or
6 telemedicine; and

7 (iii) whether the provider has the ability and
8 willingness to include in a telehealth or
9 telemedicine encounter a family caregiver who is
10 in a separate location than the patient if the
11 patient wishes and provides his or her consent;

12 (2) for hospitals:

13 (A) hospital name;

14 (B) hospital type (such as acute, rehabilitation,
15 children's, or cancer); and

16 (C) participating hospital location and telephone
17 number; and

18 (3) for facilities, other than hospitals, by type:

19 (A) facility name;

20 (B) facility type;

21 (C) types of services performed; and

22 (D) participating facility location or locations
23 and telephone numbers.

24 (e) The network plan shall include a disclosure in the
25 print format provider directory that the information included
26 in the directory is accurate as of the date of printing and

1 that beneficiaries or prospective beneficiaries should consult
2 the issuer's ~~insurer's~~ electronic provider directory on its
3 website and contact the provider. The network plan shall also
4 include a telephone number in the print format provider
5 directory for a customer service representative where the
6 beneficiary can obtain current provider directory information.

7 (f) The Director may conduct periodic audits of the
8 accuracy of provider directories. A network plan shall not be
9 subject to any fines or penalties for information required in
10 this Section that a provider submits that is inaccurate or
11 incomplete.

12 (g) This Section applies to network plans ~~that are~~ not
13 otherwise exempt under Section 3, including stand-alone dental
14 plans ~~that are subject to provider directory requirements~~
15 ~~under federal law.~~

16 (Source: P.A. 102-92, eff. 7-9-21; 103-777, eff. 1-1-25.)

17 Section 20. The Health Maintenance Organization Act is
18 amended by changing Section 5-3 as follows:

19 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

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

21 Sec. 5-3. Insurance Code provisions.

22 (a) Health Maintenance Organizations shall be subject to
23 the provisions of Sections 133, 134, 136, 137, 139, 140,
24 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,

1 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
2 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g.5-1,
3 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a,
4 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
5 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18,
6 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25,
7 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33,
8 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40,
9 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47,
10 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55,
11 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62,
12 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69,
13 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76,
14 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,
15 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,
16 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)
17 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
18 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
19 Illinois Insurance Code.

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

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

26 (2) a corporation organized under the laws of this

1 State; or

2 (3) a corporation organized under the laws of another
3 state, 30% or more of the enrollees of which are residents
4 of this State, except a corporation subject to
5 substantially the same requirements in its state of
6 organization as is a "domestic company" under Article VIII
7 1/2 of the Illinois Insurance Code.

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

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

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

23 (3) the Director shall have the power to require the
24 following information:

25 (A) certification by an independent actuary of the
26 adequacy of the reserves of the Health Maintenance

1 Organization sought to be acquired;

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

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

13 (D) such other information as the Director shall
14 require.

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

21 (e) In considering any management contract or service
22 agreement subject to Section 141.1 of the Illinois Insurance
23 Code, the Director (i) shall, in addition to the criteria
24 specified in Section 141.2 of the Illinois Insurance Code,
25 take into account the effect of the management contract or
26 service agreement on the continuation of benefits to enrollees

1 and the financial condition of the health maintenance
2 organization to be managed or serviced, and (ii) need not take
3 into account the effect of the management contract or service
4 agreement on competition.

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

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

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

1 made or additional premium to be paid pursuant to this
2 subsection (f)). The Health Maintenance Organization and
3 the group or enrollment unit may agree that the profitable
4 or unprofitable experience may be calculated taking into
5 account the refund period and the immediately preceding 2
6 plan years.

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

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

23 (g) Rulemaking authority to implement Public Act 95-1045,
24 if any, is conditioned on the rules being adopted in
25 accordance with all provisions of the Illinois Administrative
26 Procedure Act and all rules and procedures of the Joint

1 Committee on Administrative Rules; any purported rule not so
2 adopted, for whatever reason, is unauthorized.

3 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
4 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
5 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
6 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
7 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
8 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
9 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
10 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
11 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
12 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
13 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
14 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
15 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
16 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.
17 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

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

19 Sec. 5-3. Insurance Code provisions.

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

1 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
2 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
3 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
4 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
5 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
6 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
7 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
8 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
9 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
10 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,
11 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5,
12 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
13 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
14 paragraph (c) of subsection (2) of Section 367, and Articles
15 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
16 XXXIIB of the Illinois Insurance Code.

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

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

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

25 (3) a corporation organized under the laws of another
26 state, 30% or more of the enrollees of which are residents

1 of this State, except a corporation subject to
2 substantially the same requirements in its state of
3 organization as is a "domestic company" under Article VIII
4 1/2 of the Illinois Insurance Code.

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

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

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

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

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

25 (B) pro forma financial statements reflecting the
26 combined balance sheets of the acquiring company and

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

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

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

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

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

1 agreement on competition.

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

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

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

1 or unprofitable experience may be calculated taking into
2 account the refund period and the immediately preceding 2
3 plan years.

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

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

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

26 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;

1 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
2 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
3 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
4 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
5 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
6 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
7 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
8 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
9 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
10 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
11 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
12 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
13 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.
14 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
15 11-26-24.)

16 Section 25. The Limited Health Service Organization Act is
17 amended by changing Section 4003 as follows:

18 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

19 Sec. 4003. Illinois Insurance Code provisions. Limited
20 health service organizations shall be subject to the
21 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
22 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153,
23 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c,
24 355.2, 355.3, 355b, 355d, 356m, 356q, 356v, 356z.4, 356z.4a,

1 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.32,
2 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54,
3 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 356z.71,
4 356z.73, 356z.74, 356z.75, 364.3, 368a, 401, 401.1, 402, 403,
5 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA,
6 VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, ~~and~~ XXVI, and
7 XXXIIB of the Illinois Insurance Code. Nothing in this Section
8 shall require a limited health care plan to cover any service
9 that is not a limited health service. For purposes of the
10 Illinois Insurance Code, except for Sections 444 and 444.1 and
11 Articles XIII and XIII 1/2, limited health service
12 organizations in the following categories are deemed to be
13 domestic companies:

14 (1) a corporation under the laws of this State; or

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

21 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
22 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.
23 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,
24 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
25 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
26 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,

1 eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25;
2 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff.
3 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832,
4 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

5 Section 30. The Criminal Code of 2012 is amended by
6 changing Section 17-0.5 as follows:

7 (720 ILCS 5/17-0.5)

8 Sec. 17-0.5. Definitions. In this Article:

9 "Altered credit card or debit card" means any instrument
10 or device, whether known as a credit card or debit card, which
11 has been changed in any respect by addition or deletion of any
12 material, except for the signature by the person to whom the
13 card is issued.

14 "Cardholder" means the person or organization named on the
15 face of a credit card or debit card to whom or for whose
16 benefit the credit card or debit card is issued by an issuer.

17 "Computer" means a device that accepts, processes, stores,
18 retrieves, or outputs data and includes, but is not limited
19 to, auxiliary storage, including cloud-based networks of
20 remote services hosted on the Internet, and telecommunications
21 devices connected to computers.

22 "Computer network" means a set of related, remotely
23 connected devices and any communications facilities including
24 more than one computer with the capability to transmit data

1 between them through the communications facilities.

2 "Computer program" or "program" means a series of coded
3 instructions or statements in a form acceptable to a computer
4 which causes the computer to process data and supply the
5 results of the data processing.

6 "Computer services" means computer time or services,
7 including data processing services, Internet services,
8 electronic mail services, electronic message services, or
9 information or data stored in connection therewith.

10 "Counterfeit" means to manufacture, produce or create, by
11 any means, a credit card or debit card without the purported
12 issuer's consent or authorization.

13 "Credit card" means any instrument or device, whether
14 known as a credit card, credit plate, charge plate or any other
15 name, issued with or without fee by an issuer for the use of
16 the cardholder in obtaining money, goods, services or anything
17 else of value on credit or in consideration or an undertaking
18 or guaranty by the issuer of the payment of a check drawn by
19 the cardholder.

20 "Data" means a representation in any form of information,
21 knowledge, facts, concepts, or instructions, including program
22 documentation, which is prepared or has been prepared in a
23 formalized manner and is stored or processed in or transmitted
24 by a computer or in a system or network. Data is considered
25 property and may be in any form, including, but not limited to,
26 printouts, magnetic or optical storage media, punch cards, or

1 data stored internally in the memory of the computer.

2 "Debit card" means any instrument or device, known by any
3 name, issued with or without fee by an issuer for the use of
4 the cardholder in obtaining money, goods, services, and
5 anything else of value, payment of which is made against funds
6 previously deposited by the cardholder. A debit card which
7 also can be used to obtain money, goods, services and anything
8 else of value on credit shall not be considered a debit card
9 when it is being used to obtain money, goods, services or
10 anything else of value on credit.

11 "Document" includes, but is not limited to, any document,
12 representation, or image produced manually, electronically, or
13 by computer.

14 "Electronic fund transfer terminal" means any machine or
15 device that, when properly activated, will perform any of the
16 following services:

- 17 (1) Dispense money as a debit to the cardholder's
18 account; or
19 (2) Print the cardholder's account balances on a
20 statement; or
21 (3) Transfer funds between a cardholder's accounts; or
22 (4) Accept payments on a cardholder's loan; or
23 (5) Dispense cash advances on an open end credit or a
24 revolving charge agreement; or
25 (6) Accept deposits to a customer's account; or
26 (7) Receive inquiries of verification of checks and

1 dispense information that verifies that funds are
2 available to cover such checks; or

3 (8) Cause money to be transferred electronically from
4 a cardholder's account to an account held by any business,
5 firm, retail merchant, corporation, or any other
6 organization.

7 "Electronic funds transfer system", hereafter referred to
8 as "EFT System", means that system whereby funds are
9 transferred electronically from a cardholder's account to any
10 other account.

11 "Electronic mail service provider" means any person who
12 (i) is an intermediary in sending or receiving electronic mail
13 and (ii) provides to end-users of electronic mail services the
14 ability to send or receive electronic mail.

15 "Expired credit card or debit card" means a credit card or
16 debit card which is no longer valid because the term on it has
17 elapsed.

18 "False academic degree" means a certificate, diploma,
19 transcript, or other document purporting to be issued by an
20 institution of higher learning or purporting to indicate that
21 a person has completed an organized academic program of study
22 at an institution of higher learning when the person has not
23 completed the organized academic program of study indicated on
24 the certificate, diploma, transcript, or other document.

25 "False claim" means any statement made to any insurer,
26 purported insurer, servicing corporation, insurance broker, or

1 insurance agent, or any agent or employee of one of those
2 entities, and made as part of, or in support of, a claim for
3 payment or other benefit under a policy of insurance, or as
4 part of, or in support of, an application for the issuance of,
5 or the rating of, any insurance policy, when the statement
6 does any of the following:

7 (1) Contains any false, incomplete, or misleading
8 information concerning any fact or thing material to the
9 claim.

10 (2) Conceals (i) the occurrence of an event that is
11 material to any person's initial or continued right or
12 entitlement to any insurance benefit or payment or (ii)
13 the amount of any benefit or payment to which the person is
14 entitled.

15 "Financial institution" means any bank, savings and loan
16 association, credit union, or other depository of money or
17 medium of savings and collective investment.

18 "Governmental entity" means: each officer, board,
19 commission, and agency created by the Constitution, whether in
20 the executive, legislative, or judicial branch of State
21 government; each officer, department, board, commission,
22 agency, institution, authority, university, and body politic
23 and corporate of the State; each administrative unit or
24 corporate outgrowth of State government that is created by or
25 pursuant to statute, including units of local government and
26 their officers, school districts, and boards of election

1 commissioners; and each administrative unit or corporate
2 outgrowth of the foregoing items and as may be created by
3 executive order of the Governor.

4 "Incomplete credit card or debit card" means a credit card
5 or debit card which is missing part of the matter other than
6 the signature of the cardholder which an issuer requires to
7 appear on the credit card or debit card before it can be used
8 by a cardholder, and this includes credit cards or debit cards
9 which have not been stamped, embossed, imprinted or written
10 on.

11 "Institution of higher learning" means a public or private
12 college, university, or community college located in the State
13 of Illinois that is authorized by the Board of Higher
14 Education or the Illinois Community College Board to issue
15 post-secondary degrees, or a public or private college,
16 university, or community college located anywhere in the
17 United States that is or has been legally constituted to offer
18 degrees and instruction in its state of origin or
19 incorporation.

20 "Insurance company" means any "company" as defined under
21 Section 2 of the Illinois Insurance Code, "dental service plan
22 corporation" as defined in Section 3 of the Dental Service
23 Plan Act, "health maintenance organization" as defined in
24 Section 1-2 of the Health Maintenance Organization Act,
25 "limited health service organization" as defined in Section
26 1002 of the Limited Health Service Organization Act, "health

1 services plan corporation" as defined in Section 2 of the
2 Voluntary Health Services Plans Act, or any trust fund
3 organized under the Religious and Charitable Risk Pooling
4 Trust Act.

5 "Issuer" means the business organization or financial
6 institution which issues a credit card or debit card, or its
7 duly authorized agent.

8 "Merchant" has the meaning ascribed to it in Section
9 16-0.1 of this Code.

10 "Person" means any individual, corporation, government,
11 governmental subdivision or agency, business trust, estate,
12 trust, partnership or association or any other entity.

13 "Receives" or "receiving" means acquiring possession or
14 control.

15 "Record of charge form" means any document submitted or
16 intended to be submitted to an issuer as evidence of a credit
17 transaction for which the issuer has agreed to reimburse
18 persons providing money, goods, property, services or other
19 things of value.

20 "Revoked credit card or debit card" means a credit card or
21 debit card which is no longer valid because permission to use
22 it has been suspended or terminated by the issuer.

23 "Sale" means any delivery for value.

24 "Scheme or artifice to defraud" includes a scheme or
25 artifice to deprive another of the intangible right to honest
26 services.

1 "Self-insured entity" means any person, business,
2 partnership, corporation, or organization that sets aside
3 funds to meet his, her, or its losses or to absorb fluctuations
4 in the amount of loss, the losses being charged against the
5 funds set aside or accumulated.

6 "Social networking website" means an Internet website
7 containing profile web pages of the members of the website
8 that include the names or nicknames of such members,
9 photographs placed on the profile web pages by such members,
10 or any other personal or personally identifying information
11 about such members and links to other profile web pages on
12 social networking websites of friends or associates of such
13 members that can be accessed by other members or visitors to
14 the website. A social networking website provides members of
15 or visitors to such website the ability to leave messages or
16 comments on the profile web page that are visible to all or
17 some visitors to the profile web page and may also include a
18 form of electronic mail for members of the social networking
19 website.

20 "Statement" means any assertion, oral, written, or
21 otherwise, and includes, but is not limited to: any notice,
22 letter, or memorandum; proof of loss; bill of lading; receipt
23 for payment; invoice, account, or other financial statement;
24 estimate of property damage; bill for services; diagnosis or
25 prognosis; prescription; hospital, medical, or dental chart or
26 other record, x-ray, photograph, videotape, or movie film;

1 test result; other evidence of loss, injury, or expense;
2 computer-generated document; and data in any form.

3 "Universal Price Code Label" means a unique symbol that
4 consists of a machine-readable code and human-readable
5 numbers.

6 "With intent to defraud" means to act knowingly, and with
7 the specific intent to deceive or cheat, for the purpose of
8 causing financial loss to another or bringing some financial
9 gain to oneself, regardless of whether any person was actually
10 defrauded or deceived. This includes an intent to cause
11 another to assume, create, transfer, alter, or terminate any
12 right, obligation, or power with reference to any person or
13 property.

14 (Source: P.A. 101-87, eff. 1-1-20.)

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

22 Section 99. Effective date. This Act takes effect upon
23 becoming law, except that the changes to Section 1563 of the
24 Illinois Insurance Code take effect January 1, 2026, and the
25 changes to Section 174 of the Illinois Insurance Code take

1 effect 60 days after becoming law.