



Sen. Julie A. Morrison

**Filed: 5/5/2025**

10400HB3800sam001

LRB104 09780 BAB 25803 a

1 AMENDMENT TO HOUSE BILL 3800

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 3800 by replacing  
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by  
5 changing Sections 121-2.08, 155.04, 174, 194, 368d, 370c.1,  
6 and 1563 and by renumbering and changing Section 356z.71 (as  
7 amended by 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

1 subsection (1) of Section 445 of this Code.

2 "Industrial insured" means an insured:

3 (i) that procures the insurance of any risk or risks  
4 of the kinds specified in Classes 2 and 3 of Section 4 of  
5 this Code by use of the services of a full-time employee  
6 who is a qualified risk manager or the services of a  
7 regularly and continuously retained consultant who is a  
8 qualified risk manager;

9 (ii) that procures the insurance ~~directly from an~~  
10 ~~unauthorized insurer~~ without the services of an  
11 intermediary insurance producer; and

12 (iii) that is an exempt commercial purchaser whose  
13 home state is Illinois.

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

16 "Qualified risk manager" means qualified risk manager as  
17 the term is defined in subsection (1) of Section 445 of this  
18 Code.

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

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

24 (b) For contracts of insurance procured directly from an  
25 unauthorized insurer effective January 1, 2015 or later,  
26 within 90 days after the effective date of each contract of

1 insurance issued under this Section, the insured shall file a  
2 report with the Director by submitting the report to the  
3 Surplus Line Association of Illinois in writing or in a  
4 computer readable format and provide information as designated  
5 by the Surplus Line Association of Illinois. The information  
6 in the report shall be substantially similar to that required  
7 for surplus line submissions as described in subsection (5) of  
8 Section 445 of this Code. Where applicable, the report shall  
9 satisfy, with respect to the subject insurance, the reporting  
10 requirement of Section 12 of the Fire Investigation Act.

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

1 for insurance subject to tax under Section 12 of the Fire  
2 Investigation Act. For contracts of insurance procured  
3 directly from an unauthorized insurer effective January 1,  
4 2015 or later, within 30 days after filing the report, the  
5 insured shall pay to the Surplus Line Association of Illinois  
6 a countersigning fee that shall be assessed at the same rate  
7 charged to members pursuant to subsection (4) of Section 445.1  
8 of this Code.

9 (d) For contracts of insurance procured directly from an  
10 unauthorized insurer effective January 1, 2015 or later, the  
11 insured shall withhold the amount of the taxes and  
12 countersignature fee from the amount of premium charged by and  
13 otherwise payable to the insurer for the insurance. If the  
14 insured fails to withhold the tax and countersignature fee  
15 from the premium, then the insured shall be liable for the  
16 amounts thereof and shall pay the amounts as prescribed in  
17 subsection (c) of this Section.

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

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

22 (215 ILCS 5/155.04) (from Ch. 73, par. 767.4)

23 Sec. 155.04. Standards for companies and officials.

24 (1) The Director shall not approve any declaration of  
25 organization or Articles of Incorporation or issue a

1 Certificate of Authority to any company until he has found  
2 that:

3 (a) the company has submitted a sound plan of  
4 operation; ~~and~~

5 (b) ~~the general character and experience of the~~  
6 ~~incorporators, directors, and proposed officers is such as~~  
7 ~~to assure reasonable promise of a successful operation,~~  
8 ~~based on the fact that such persons~~ are of known good  
9 character and that there is no good reason to believe that  
10 they are affiliated, directly or indirectly, through  
11 ownership, control, management, reinsurance transactions  
12 or other insurance of business relations with any person  
13 or persons known to have been involved in the improper  
14 manipulation of assets, accounts or reinsurance;

15 (c) the general experience of the incorporators,  
16 directors, and proposed officers is enough to ensure the  
17 reasonable promise of a successful operation; and

18 (d) no financial concerns related to the company, its  
19 ownership, its associated group, or its affiliates have  
20 been identified that raise the possibility that the  
21 company will have solvency concerns or problems generating  
22 the necessary levels of capital and surplus.

23 The Director may require, in substantially the same form,  
24 the information required under Section 131.5 of this Code.

25 (2) All companies licensed to do business in this state  
26 must notify the Director within 30 days of the appointment or

1 election of any new officers or directors.

2 (3) Except in cases where the Director deems that any  
3 officer or director meets the standards set forth in this  
4 section, he shall, after notice and hearing afforded to the  
5 officer or director, and after a finding that the officer or  
6 director is incompetent or untrustworthy or of known bad  
7 character, order the removal of the person. If a company does  
8 not comply with a removal order within 30 days, the Director  
9 shall suspend that company's Certificate of Authority until  
10 such time as the order is complied with.

11 (4) It shall be unlawful for a company to borrow money or  
12 receive a loan or advance from anyone convicted of a felony,  
13 anyone who is untrustworthy or of known bad character or  
14 anyone convicted of a criminal offense involving the  
15 conversion or misappropriation of fiduciary funds or insurance  
16 accounts, theft, deceit, fraud, misrepresentation or  
17 corruption.

18 (Source: P.A. 89-97, eff. 7-7-95.)

19 (215 ILCS 5/174) (from Ch. 73, par. 786)

20 Sec. 174. Kinds of agreements requiring approval.

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

24 (a) Agreements of reinsurance of any such company  
25 transacting the kind or kinds of business enumerated in

1 Class 1 of Section 4, or as a Fraternal Benefit Society  
2 under Article XVII, a Mutual Benefit Association under  
3 Article XVIII, a Burial Society under Article XIX or an  
4 Assessment Accident and Assessment Accident and Health  
5 Company under Article XXI, cedes previously issued and  
6 outstanding risks to any company, or cedes any risks to a  
7 company not authorized to transact business in this State,  
8 or assumes any outstanding risks on which the aggregate  
9 reserves and claim liabilities exceed 20% ~~20 percent~~ of  
10 the aggregate reserves and claim liabilities of the  
11 assuming company, as reported in the preceding annual  
12 statement, for the business of either life or accident and  
13 health insurance.

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

1           reinsurance contract.

2           (c) (Blank).

3           (2) Requests for approval shall be filed at least 30  
4 working days prior to the stated effective date of the  
5 agreement. An agreement which is not disapproved by the  
6 Director within 30 working ~~thirty~~ days after its complete  
7 submission shall be deemed approved.

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

9           (215 ILCS 5/194) (from Ch. 73, par. 806)

10           Sec. 194. Rights and liabilities of creditors fixed upon  
11 liquidation.

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

21           (b) The Director may, within 2 years after the entry of an  
22 order for rehabilitation or liquidation or within such further  
23 time as applicable law permits, institute an action, claim,  
24 suit, or proceeding upon any cause of action against which the  
25 period of limitation fixed by applicable law has not expired

1 at the time of filing of the complaint upon which the order is  
2 entered.

3 (c) The time between the filing of a complaint for  
4 conservation, rehabilitation, or liquidation against the  
5 company and the denial of the complaint shall not be  
6 considered to be a part of the time within which any action may  
7 be commenced against the company. Any action against the  
8 company that might have been commenced when the complaint was  
9 filed may be commenced for at least 180 days after the  
10 complaint is denied.

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

1 the contracts or coverage by transferring them to an assuming  
2 reinsurer, or (2) distributing dividends under Section 210 of  
3 this Article. Claims incurred during the extension of coverage  
4 provided for in this Article shall be classified at priority  
5 level (d) under paragraph (1) of Section 205 of this Article.

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

7 (215 ILCS 5/356z.73)

8 Sec. 356z.73 ~~356z.71~~. Insurance coverage for dependent  
9 parents.

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

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

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

24 (215 ILCS 5/368d)

1           Sec. 368d. Recoupments.

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

23           (b) It is not a recoupment when a health care professional  
24 or health care provider is paid an amount prospectively or  
25 concurrently under a contract with an insurer, health  
26 maintenance organization, independent practice association, or

1 physician hospital organization that requires a retrospective  
2 reconciliation based upon specific conditions outlined in the  
3 contract.

4 (c) No recoupment or offset may be requested or withheld  
5 from future payments 12 months or more after the original  
6 payment is made, except in cases in which:

7 (1) a court, government administrative agency, other  
8 tribunal, or independent third-party arbitrator makes or  
9 has made a formal finding of fraud or material  
10 misrepresentation;

11 (2) an insurer is acting as a plan administrator for  
12 the Comprehensive Health Insurance Plan under the  
13 Comprehensive Health Insurance Plan Act;

14 (3) the provider has already been paid in full by any  
15 other payer, third party, or workers' compensation  
16 insurer; ~~or~~

17 (4) an insurer contracted with the Department of  
18 Healthcare and Family Services is required by the  
19 Department of Healthcare and Family Services to recoup or  
20 offset payments due to a federal Medicaid requirement; ~~or~~

21 (5) the insurer has requested the recoupment or offset  
22 within 12 months, but the insurer and the health care  
23 professional or health care provider mutually agree to a  
24 different time limit for the recoupment or offset to be  
25 withheld from future payments.

26 No contract between an insurer and a health care professional

1 or health care provider may provide for recoupments in  
2 violation of this Section. Nothing in this Section shall be  
3 construed to preclude insurers, health maintenance  
4 organizations, independent practice associations, or physician  
5 hospital organizations from resolving coordination of benefits  
6 between or among each other, including, but not limited to,  
7 resolution of workers' compensation and third-party liability  
8 cases, without recouping payment from the provider beyond the  
9 12-month ~~18-month~~ time limit provided in this subsection (c).

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

11 (215 ILCS 5/370c.1)

12 Sec. 370c.1. Mental, emotional, nervous, or substance use  
13 disorder or condition parity.

14 (a) On and after July 23, 2021 (the effective date of  
15 Public Act 102-135), every insurer that amends, delivers,  
16 issues, or renews a group or individual policy of accident and  
17 health insurance or a qualified health plan offered through  
18 the Health Insurance Marketplace in this State providing  
19 coverage for hospital or medical treatment and for the  
20 treatment of mental, emotional, nervous, or substance use  
21 disorders or conditions shall ensure prior to policy issuance  
22 that:

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

1 predominant financial requirements applied to  
2 substantially all hospital and medical benefits covered by  
3 the policy and that there are no separate cost-sharing  
4 requirements that are applicable only with respect to  
5 mental, emotional, nervous, or substance use disorder or  
6 condition benefits; and

7 (2) the treatment limitations applicable to such  
8 mental, emotional, nervous, or substance use disorder or  
9 condition benefits are no more restrictive than the  
10 predominant treatment limitations applied to substantially  
11 all hospital and medical benefits covered by the policy  
12 and that there are no separate treatment limitations that  
13 are applicable only with respect to mental, emotional,  
14 nervous, or substance use disorder or condition benefits.

15 (b) The following provisions shall apply concerning  
16 aggregate lifetime limits:

17 (1) In the case of a group or individual policy of  
18 accident and health insurance or a qualified health plan  
19 offered through the Health Insurance Marketplace amended,  
20 delivered, issued, or renewed in this State on or after  
21 September 9, 2015 (the effective date of Public Act  
22 99-480) that provides coverage for hospital or medical  
23 treatment and for the treatment of mental, emotional,  
24 nervous, or substance use disorders or conditions the  
25 following provisions shall apply:

26 (A) if the policy does not include an aggregate

1 lifetime limit on substantially all hospital and  
2 medical benefits, then the policy may not impose any  
3 aggregate lifetime limit on mental, emotional,  
4 nervous, or substance use disorder or condition  
5 benefits; or

6 (B) if the policy includes an aggregate lifetime  
7 limit on substantially all hospital and medical  
8 benefits (in this subsection referred to as the  
9 "applicable lifetime limit"), then the policy shall  
10 either:

11 (i) apply the applicable lifetime limit both  
12 to the hospital and medical benefits to which it  
13 otherwise would apply and to mental, emotional,  
14 nervous, or substance use disorder or condition  
15 benefits and not distinguish in the application of  
16 the limit between the hospital and medical  
17 benefits and mental, emotional, nervous, or  
18 substance use disorder or condition benefits; or

19 (ii) not include any aggregate lifetime limit  
20 on mental, emotional, nervous, or substance use  
21 disorder or condition benefits that is less than  
22 the applicable lifetime limit.

23 (2) In the case of a policy that is not described in  
24 paragraph (1) of subsection (b) of this Section and that  
25 includes no or different aggregate lifetime limits on  
26 different categories of hospital and medical benefits, the

1 Director shall establish rules under which subparagraph  
2 (B) of paragraph (1) of subsection (b) of this Section is  
3 applied to such policy with respect to mental, emotional,  
4 nervous, or substance use disorder or condition benefits  
5 by substituting for the applicable lifetime limit an  
6 average aggregate lifetime limit that is computed taking  
7 into account the weighted average of the aggregate  
8 lifetime limits applicable to such categories.

9 (c) The following provisions shall apply concerning annual  
10 limits:

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

20 (A) if the policy does not include an annual limit  
21 on substantially all hospital and medical benefits,  
22 then the policy may not impose any annual limits on  
23 mental, emotional, nervous, or substance use disorder  
24 or condition benefits; or

25 (B) if the policy includes an annual limit on  
26 substantially all hospital and medical benefits (in

1           this subsection referred to as the "applicable annual  
2           limit"), then the policy shall either:

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

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

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

1           (d) With respect to mental, emotional, nervous, or  
2 substance use disorders or conditions, an insurer shall use  
3 policies and procedures for the election and placement of  
4 mental, emotional, nervous, or substance use disorder or  
5 condition treatment drugs on their formulary that are no less  
6 favorable to the insured as those policies and procedures the  
7 insurer uses for the selection and placement of drugs for  
8 medical or surgical conditions and shall follow the expedited  
9 coverage determination requirements for substance abuse  
10 treatment drugs set forth in Section 45.2 of the Managed Care  
11 Reform and Patient Rights Act.

12           (e) This Section shall be interpreted in a manner  
13 consistent with all applicable federal parity regulations  
14 including, but not limited to, the Paul Wellstone and Pete  
15 Domenici Mental Health Parity and Addiction Equity Act of  
16 2008, final regulations issued under the Paul Wellstone and  
17 Pete Domenici Mental Health Parity and Addiction Equity Act of  
18 2008 and final regulations applying the Paul Wellstone and  
19 Pete Domenici Mental Health Parity and Addiction Equity Act of  
20 2008 to Medicaid managed care organizations, the Children's  
21 Health Insurance Program, and alternative benefit plans.

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

25           (g) As used in this Section:

26           "Financial requirement" includes deductibles, copayments,

1 coinsurance, and out-of-pocket maximums, but does not include  
2 an aggregate lifetime limit or an annual limit subject to  
3 subsections (b) and (c).

4 "Mental, emotional, nervous, or substance use disorder or  
5 condition" means a condition or disorder that involves a  
6 mental health condition or substance use disorder that falls  
7 under any of the diagnostic categories listed in the mental  
8 and behavioral disorders chapter of the current edition of the  
9 International Classification of Disease or that is listed in  
10 the most recent version of the Diagnostic and Statistical  
11 Manual of Mental Disorders.

12 "Treatment limitation" includes limits on benefits based  
13 on the frequency of treatment, number of visits, days of  
14 coverage, days in a waiting period, or other similar limits on  
15 the scope or duration of treatment. "Treatment limitation"  
16 includes both quantitative treatment limitations, which are  
17 expressed numerically (such as 50 outpatient visits per year),  
18 and nonquantitative treatment limitations, which otherwise  
19 limit the scope or duration of treatment. A permanent  
20 exclusion of all benefits for a particular condition or  
21 disorder shall not be considered a treatment limitation.

22 "Nonquantitative treatment" means those limitations as  
23 described under federal regulations (26 CFR 54.9812-1).

24 "Nonquantitative treatment limitations" include, but are not  
25 limited to, those limitations described under federal  
26 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR

1 146.136.

2 (h) The Department of Insurance shall implement the  
3 following education initiatives:

4 (1) By January 1, 2016, the Department shall develop a  
5 plan for a Consumer Education Campaign on parity. The  
6 Consumer Education Campaign shall focus its efforts  
7 throughout the State and include trainings in the  
8 northern, southern, and central regions of the State, as  
9 defined by the Department, as well as each of the 5 managed  
10 care regions of the State as identified by the Department  
11 of Healthcare and Family Services. Under this Consumer  
12 Education Campaign, the Department shall: (1) by January  
13 1, 2017, provide at least one live training in each region  
14 on parity for consumers and providers and one webinar  
15 training to be posted on the Department website and (2)  
16 establish a consumer hotline to assist consumers in  
17 navigating the parity process by March 1, 2017. By January  
18 1, 2018 the Department shall issue a report to the General  
19 Assembly on the success of the Consumer Education  
20 Campaign, which shall indicate whether additional training  
21 is necessary or would be recommended.

22 (2) (Blank). ~~The Department, in coordination with the~~  
23 ~~Department of Human Services and the Department of~~  
24 ~~Healthcare and Family Services, shall convene a working~~  
25 ~~group of health care insurance carriers, mental health~~  
26 ~~advocacy groups, substance abuse patient advocacy groups,~~

1 ~~and mental health physician groups for the purpose of~~  
2 ~~discussing issues related to the treatment and coverage of~~  
3 ~~mental, emotional, nervous, or substance use disorders or~~  
4 ~~conditions and compliance with parity obligations under~~  
5 ~~State and federal law. Compliance shall be measured,~~  
6 ~~tracked, and shared during the meetings of the working~~  
7 ~~group. The working group shall meet once before January 1,~~  
8 ~~2016 and shall meet semiannually thereafter. The~~  
9 ~~Department shall issue an annual report to the General~~  
10 ~~Assembly that includes a list of the health care insurance~~  
11 ~~carriers, mental health advocacy groups, substance abuse~~  
12 ~~patient advocacy groups, and mental health physician~~  
13 ~~groups that participated in the working group meetings,~~  
14 ~~details on the issues and topics covered, and any~~  
15 ~~legislative recommendations developed by the working~~  
16 ~~group.~~

17 (3) Not later than January 1 of each year, the  
18 Department, in conjunction with the Department of  
19 Healthcare and Family Services, shall issue a joint report  
20 to the General Assembly and provide an educational  
21 presentation to the General Assembly. The report and  
22 presentation shall:

23 (A) Cover the methodology the Departments use to  
24 check for compliance with the federal Paul Wellstone  
25 and Pete Domenici Mental Health Parity and Addiction  
26 Equity Act of 2008, 42 U.S.C. 18031(j), and any

1 federal regulations or guidance relating to the  
2 compliance and oversight of the federal Paul Wellstone  
3 and Pete Domenici Mental Health Parity and Addiction  
4 Equity Act of 2008 and 42 U.S.C. 18031(j).

5 (B) Cover the methodology the Departments use to  
6 check for compliance with this Section and Sections  
7 356z.23 and 370c of this Code.

8 (C) Identify market conduct examinations or, in  
9 the case of the Department of Healthcare and Family  
10 Services, audits conducted or completed during the  
11 preceding 12-month period regarding compliance with  
12 parity in mental, emotional, nervous, and substance  
13 use disorder or condition benefits under State and  
14 federal laws and summarize the results of such market  
15 conduct examinations and audits. This shall include:

16 (i) the number of market conduct examinations  
17 and audits initiated and completed;

18 (ii) the benefit classifications examined by  
19 each market conduct examination and audit;

20 (iii) the subject matter of each market  
21 conduct examination and audit, including  
22 quantitative and nonquantitative treatment  
23 limitations; and

24 (iv) a summary of the basis for the final  
25 decision rendered in each market conduct  
26 examination and audit.

1 Individually identifiable information shall be  
2 excluded from the reports consistent with federal  
3 privacy protections.

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

10 (E) The report must be written in non-technical,  
11 readily understandable language and shall be made  
12 available to the public by, among such other means as  
13 the Departments find appropriate, posting the report  
14 on the Departments' websites.

15 (i) The Parity Advancement Fund is created as a special  
16 fund in the State treasury. Moneys from fines and penalties  
17 collected from insurers for violations of this Section shall  
18 be deposited into the Fund. Moneys deposited into the Fund for  
19 appropriation by the General Assembly to the Department shall  
20 be used for the purpose of providing financial support of the  
21 Consumer Education Campaign, parity compliance advocacy, and  
22 other initiatives that support parity implementation and  
23 enforcement on behalf of consumers.

24 (j) (Blank).

25 (j-5) The Department of Insurance shall collect the  
26 following information:

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

4                   (A) individual short-term policies;

5                   (B) individual long-term policies;

6                   (C) group short-term policies; and

7                   (D) group long-term policies.

8           (2) The number of policies referenced in paragraph (1)  
9 of this subsection that limit mental health and substance  
10 use disorder benefits.

11           (3) The average defined benefit period for the  
12 policies referenced in paragraph (1) of this subsection,  
13 both for those policies that limit and those policies that  
14 have no limitation on mental health and substance use  
15 disorder benefits.

16           (4) Whether the policies referenced in paragraph (1)  
17 of this subsection are purchased on a voluntary or  
18 non-voluntary basis.

19           (5) The identities of the individuals, entities, or a  
20 combination of the 2 that assume the cost associated with  
21 covering the policies referenced in paragraph (1) of this  
22 subsection.

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

26                   (A) individual short-term policies;

1 (B) individual long-term policies;

2 (C) group short-term policies; and

3 (D) group long-term policies.

4 (7) The average premiums for disability income  
5 insurance issued in this State for:

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

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

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

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

14 (E) individual short-term policies that include  
15 mental health and substance use disorder benefits  
16 without limitation;

17 (F) individual long-term policies that include  
18 mental health and substance use disorder benefits  
19 without limitation;

20 (G) group short-term policies that include mental  
21 health and substance use disorder benefits without  
22 limitation; and

23 (H) group long-term policies that include mental  
24 health and substance use disorder benefits without  
25 limitation.

26 The Department shall present its findings regarding

1 information collected under this subsection (j-5) to the  
2 General Assembly no later than April 30, 2024. Information  
3 regarding a specific insurance provider's contributions to the  
4 Department's report shall be exempt from disclosure under  
5 paragraph (t) of subsection (1) of Section 7 of the Freedom of  
6 Information Act. The aggregated information gathered by the  
7 Department shall not be exempt from disclosure under paragraph  
8 (t) of subsection (1) of Section 7 of the Freedom of  
9 Information Act.

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

1 assistance:

2 (1) A summary of the plan's pharmacy management  
3 processes for mental, emotional, nervous, or substance use  
4 disorder or condition benefits compared to those for other  
5 medical benefits.

6 (2) A summary of the internal processes of review for  
7 experimental benefits and unproven technology for mental,  
8 emotional, nervous, or substance use disorder or condition  
9 benefits and those for other medical benefits.

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

14 (4) A description of the process used to develop or  
15 select the medical necessity criteria for mental,  
16 emotional, nervous, or substance use disorder or condition  
17 benefits and the process used to develop or select the  
18 medical necessity criteria for medical and surgical  
19 benefits.

20 (5) Identification of all nonquantitative treatment  
21 limitations that are applied to both mental, emotional,  
22 nervous, or substance use disorder or condition benefits  
23 and medical and surgical benefits within each  
24 classification of benefits.

25 (6) The results of an analysis that demonstrates that  
26 for the medical necessity criteria described in

1        subparagraph (A) and for each nonquantitative treatment  
2        limitation identified in subparagraph (B), as written and  
3        in operation, the processes, strategies, evidentiary  
4        standards, or other factors used in applying the medical  
5        necessity criteria and each nonquantitative treatment  
6        limitation to mental, emotional, nervous, or substance use  
7        disorder or condition benefits within each classification  
8        of benefits are comparable to, and are applied no more  
9        stringently than, the processes, strategies, evidentiary  
10       standards, or other factors used in applying the medical  
11       necessity criteria and each nonquantitative treatment  
12       limitation to medical and surgical benefits within the  
13       corresponding classification of benefits; at a minimum,  
14       the results of the analysis shall:

15                (A) identify the factors used to determine that a  
16                nonquantitative treatment limitation applies to a  
17                benefit, including factors that were considered but  
18                rejected;

19                (B) identify and define the specific evidentiary  
20                standards used to define the factors and any other  
21                evidence relied upon in designing each nonquantitative  
22                treatment limitation;

23                (C) provide the comparative analyses, including  
24                the results of the analyses, performed to determine  
25                that the processes and strategies used to design each  
26                nonquantitative treatment limitation, as written, for

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

7           (D) provide the comparative analyses, including  
8           the results of the analyses, performed to determine  
9           that the processes and strategies used to apply each  
10          nonquantitative treatment limitation, in operation,  
11          for mental, emotional, nervous, or substance use  
12          disorder or condition benefits are comparable to, and  
13          applied no more stringently than, the processes or  
14          strategies used to apply each nonquantitative  
15          treatment limitation, in operation, for medical and  
16          surgical benefits; and

17          (E) disclose the specific findings and conclusions  
18          reached by the insurer that the results of the  
19          analyses described in subparagraphs (C) and (D)  
20          indicate that the insurer is in compliance with this  
21          Section and the Mental Health Parity and Addiction  
22          Equity Act of 2008 and its implementing regulations,  
23          which includes 42 CFR Parts 438, 440, and 457 and 45  
24          CFR 146.136 and any other related federal regulations  
25          found in the Code of Federal Regulations.

26          (7) Any other information necessary to clarify data

1 provided in accordance with this Section requested by the  
2 Director, including information that may be proprietary or  
3 have commercial value, under the requirements of Section  
4 30 of the Viatical Settlements Act of 2009.

5 (l) An insurer that amends, delivers, issues, or renews a  
6 group or individual policy of accident and health insurance or  
7 a qualified health plan offered through the health insurance  
8 marketplace in this State providing coverage for hospital or  
9 medical treatment and for the treatment of mental, emotional,  
10 nervous, or substance use disorders or conditions on or after  
11 January 1, 2019 (the effective date of Public Act 100-1024)  
12 shall, in advance of the plan year, make available to the  
13 Department or, with respect to medical assistance, the  
14 Department of Healthcare and Family Services and to all plan  
15 participants and beneficiaries the information required in  
16 subparagraphs (C) through (E) of paragraph (6) of subsection  
17 (k). For plan participants and medical assistance  
18 beneficiaries, the information required in subparagraphs (C)  
19 through (E) of paragraph (6) of subsection (k) shall be made  
20 available on a publicly available website whose web address is  
21 prominently displayed in plan and managed care organization  
22 informational and marketing materials.

23 (m) In conjunction with its compliance examination program  
24 conducted in accordance with the Illinois State Auditing Act,  
25 the Auditor General shall undertake a review of compliance by  
26 the Department and the Department of Healthcare and Family

1 Services with Section 370c and this Section. Any findings  
2 resulting from the review conducted under this Section shall  
3 be included in the applicable State agency's compliance  
4 examination report. Each compliance examination report shall  
5 be issued in accordance with Section 3-14 of the Illinois  
6 State Auditing Act. A copy of each report shall also be  
7 delivered to the head of the applicable State agency and  
8 posted on the Auditor General's website.

9 (Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21;  
10 102-813, eff. 5-13-22; 103-94, eff. 1-1-24; 103-105, eff.  
11 6-27-23; 103-605, eff. 7-1-24.)

12 (215 ILCS 5/1563)

13 Sec. 1563. Fees. The fees required by this Article are as  
14 follows:

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

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

20 (3) Application fee of \$50 for processing each request  
21 to take the written examination for a public adjuster  
22 license.

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

24 Section 10. The Dental Care Patient Protection Act is

1 amended by changing Section 75 as follows:

2 (215 ILCS 109/75)

3 Sec. 75. Application of other law.

4 (a) All provisions of this Act and other applicable law  
5 that are not in conflict with this Act shall apply to managed  
6 care dental plans and other persons subject to this Act. To the  
7 extent that any provision of this Act or rule under this Act  
8 would prevent the application of any standard or requirement  
9 under the Network Adequacy and Transparency Act to a plan that  
10 is subject to both statutes, the Network Adequacy and  
11 Transparency Act shall supersede this Act.

12 (b) Solicitation of enrollees by a managed care entity  
13 granted a certificate of authority or its representatives  
14 shall not be construed to violate any provision of law  
15 relating to solicitation or advertising by health  
16 professionals.

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

18 Section 15. The Network Adequacy and Transparency Act is  
19 amended by changing Sections 3, 5, 10, and 25 as follows:

20 (215 ILCS 124/3)

21 Sec. 3. Applicability of Act. This Act applies to an  
22 individual or group policy of health insurance coverage with a  
23 network plan amended, delivered, issued, or renewed in this

1 State on or after January 1, 2019. This Act does not apply to  
2 an individual or group policy for excepted benefits or  
3 short-term, limited-duration health insurance coverage with a  
4 network plan. This Act does not apply to stand-alone dental  
5 plans. If federal law establishes network adequacy and  
6 transparency standards for stand-alone dental plans, the  
7 Department shall enforce those applicable federal requirements  
8 ~~, except to the extent that federal law establishes network~~  
9 ~~adequacy and transparency standards for stand-alone dental~~  
10 ~~plans, which the Department shall enforce for plans amended,~~  
11 ~~delivered, issued, or renewed on or after January 1, 2025.~~

12 (Source: P.A. 103-650, eff. 1-1-25; 103-777, eff. 1-1-25;  
13 revised 11-26-24.)

14 (215 ILCS 124/5)

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

16 Sec. 5. Definitions. In this Act:

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

23 "Beneficiary" means an individual, an enrollee, an  
24 insured, a participant, or any other person entitled to  
25 reimbursement for covered expenses of or the discounting of

1 provider fees for health care services under a program in  
2 which the beneficiary has an incentive to utilize the services  
3 of a provider that has entered into an agreement or  
4 arrangement with an issuer.

5 "Department" means the Department of Insurance.

6 "Director" means the Director of Insurance.

7 "Essential community provider" has the meaning given  
8 ~~ascribed~~ to that term in 45 CFR 156.235.

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

11 "Excepted benefits" includes individual, group, or blanket  
12 coverage.

13 "Exchange" has the meaning given ~~ascribed~~ to that term in  
14 45 CFR 155.20.

15 ~~"Director" means the Director of Insurance.~~

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

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

25 "Health insurance coverage" has the meaning given ~~ascribed~~  
26 to that term in Section 5 of the Illinois Health Insurance

1 Portability and Accountability Act. "Health insurance  
2 coverage" does not include any coverage or benefits under  
3 Medicare or under the medical assistance program established  
4 under Article V of the Illinois Public Aid Code.

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

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

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

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

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

1 "Preferred provider" means any provider who has entered,  
2 either directly or indirectly, into an agreement with an  
3 employer or risk-bearing entity relating to health care  
4 services that may be rendered to beneficiaries under a network  
5 plan.

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

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

19 "Stand-alone dental plan" has the meaning given ~~ascribed~~  
20 to that term in 45 CFR 156.400.

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

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

25 "Tiered network" means a network that identifies and  
26 groups some or all types of provider and facilities into

1 specific groups to which different provider reimbursement,  
2 covered person cost-sharing or provider access requirements,  
3 or any combination thereof, apply for the same services.

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

7 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;  
8 103-650, eff. 1-1-25.)

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

10 Sec. 5. Definitions. In this Act:

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

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

24 "Department" means the Department of Insurance.

25 "Director" means the Director of Insurance.

1       "Essential community provider" has the meaning given to  
2 that term in 45 CFR 156.235.

3       "Excepted benefits" has the meaning given to that term in  
4 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted  
5 benefits" includes individual, group, or blanket coverage.

6       "Exchange" has the meaning given to that term in 45 CFR  
7 155.20.

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

14       "Group health plan" has the meaning given to that term in  
15 Section 5 of the Illinois Health Insurance Portability and  
16 Accountability Act.

17       "Health insurance coverage" has the meaning given to that  
18 term in Section 5 of the Illinois Health Insurance Portability  
19 and Accountability Act. "Health insurance coverage" does not  
20 include any coverage or benefits under Medicare or under the  
21 medical assistance program established under Article V of the  
22 Illinois Public Aid Code.

23       "Issuer" means a "health insurance issuer" as defined in  
24 Section 5 of the Illinois Health Insurance Portability and  
25 Accountability Act. ~~"Insurer" means any entity that offers~~  
26 ~~individual or group accident and health insurance, including,~~

1 ~~but not limited to, health maintenance organizations,~~  
2 ~~preferred provider organizations, exclusive provider~~  
3 ~~organizations, and other plan structures requiring network~~  
4 ~~participation, excluding the medical assistance program under~~  
5 ~~the Illinois Public Aid Code, the State employees group health~~  
6 ~~insurance program, workers compensation insurance, and~~  
7 ~~pharmacy benefit managers.~~

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

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

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

1 ~~insurer.~~

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

1 recurrence of symptoms.

2 "Preferred provider" means any provider who has entered,  
3 either directly or indirectly, into an agreement with an  
4 employer or risk-bearing entity relating to health care  
5 services that may be rendered to beneficiaries under a network  
6 plan.

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

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 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;  
23 103-718, eff. 7-19-24.)

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

25 Sec. 5. Definitions. In this Act:

1 "Authorized representative" means a person to whom a  
2 beneficiary has given express written consent to represent the  
3 beneficiary; a person authorized by law to provide substituted  
4 consent for a beneficiary; or the beneficiary's treating  
5 provider only when the beneficiary or his or her family member  
6 is unable to provide consent.

7 "Beneficiary" means an individual, an enrollee, an  
8 insured, a participant, or any other person entitled to  
9 reimbursement for covered expenses of or the discounting of  
10 provider fees for health care services under a program in  
11 which the beneficiary has an incentive to utilize the services  
12 of a provider that has entered into an agreement or  
13 arrangement with an issuer ~~insurer~~.

14 "Department" means the Department of Insurance.

15 "Director" means the Director of Insurance.

16 "Essential community provider" has the meaning given to  
17 that term in 45 CFR 156.235.

18 "Excepted benefits" has the meaning given to that term in  
19 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted  
20 benefits" includes individual, group, or blanket coverage.

21 "Exchange" has the meaning given to that term in 45 CFR  
22 155.20.

23 "Family caregiver" means a relative, partner, friend, or  
24 neighbor who has a significant relationship with the patient  
25 and administers or assists the patient with activities of  
26 daily living, instrumental activities of daily living, or

1 other medical or nursing tasks for the quality and welfare of  
2 that patient.

3 "Group health plan" has the meaning given to that term in  
4 Section 5 of the Illinois Health Insurance Portability and  
5 Accountability Act.

6 "Health insurance coverage" has the meaning given to that  
7 term in Section 5 of the Illinois Health Insurance Portability  
8 and Accountability Act. "Health insurance coverage" does not  
9 include any coverage or benefits under Medicare or under the  
10 medical assistance program established under Article V of the  
11 Illinois Public Aid Code.

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 within any county, the removal of a major

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

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

9 "Network plan" means an individual or group policy of  
10 ~~accident and~~ health insurance coverage that either requires a  
11 covered person to use or creates incentives, including  
12 financial incentives, for a covered person to use providers  
13 managed, owned, under contract with, or employed by the issuer  
14 or by a third party contracted to arrange, contract for, or  
15 administer such provider-related incentives for the issuer  
16 insurer.

17 "Ongoing course of treatment" means (1) treatment for a  
18 life-threatening condition, which is a disease or condition  
19 for which likelihood of death is probable unless the course of  
20 the disease or condition is interrupted; (2) treatment for a  
21 serious acute condition, defined as a disease or condition  
22 requiring complex ongoing care that the covered person is  
23 currently receiving, such as chemotherapy, radiation therapy,  
24 ~~or~~ post-operative visits, or a serious and complex condition  
25 as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of  
26 treatment for a health condition that a treating provider

1 attests that discontinuing care by that provider would worsen  
2 the condition or interfere with anticipated outcomes; ~~or~~ (4)  
3 the third trimester of pregnancy through the post-partum  
4 period; (5) undergoing a course of institutional or inpatient  
5 care from the provider within the meaning of 42 U.S.C.  
6 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective  
7 surgery from the provider, including receipt of preoperative  
8 or postoperative care from such provider with respect to such  
9 a surgery; (7) being determined to be terminally ill, as  
10 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving  
11 treatment for such illness from such provider; or (8) any  
12 other treatment of a condition or disease that requires  
13 repeated health care services pursuant to a plan of treatment  
14 by a provider because of the potential for changes in the  
15 therapeutic regimen or because of the potential for a  
16 recurrence of symptoms.

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

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

26 ~~"Short term, limited duration health insurance coverage~~

1 ~~has the meaning given to that term in Section 5 of the~~  
2 ~~Short-Term, Limited Duration Health Insurance Coverage Act.~~

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

5 "Telehealth" has the meaning given to that term in Section  
6 356z.22 of the Illinois Insurance Code.

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

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

14 ~~"Woman's principal health care provider" means a physician~~  
15 ~~licensed to practice medicine in all of its branches~~  
16 ~~specializing in obstetrics, gynecology, or family practice.~~

17 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;  
18 103-777, eff. 1-1-25.)

19 (215 ILCS 124/10)

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

21 Sec. 10. Network adequacy.

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

25 (1) The written policies and procedures for adding

1 providers to meet patient needs based on increases in the  
2 number of beneficiaries, changes in the  
3 patient-to-provider ratio, changes in medical and health  
4 care capabilities, and increased demand for services.

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

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

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

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

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

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

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

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

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

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

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

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

26                   (D) a description of how the use of telemedicine,

1 telehealth, or mobile care services may be used to  
2 partially meet the network adequacy standards, if  
3 applicable.

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

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

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

19 (8) A limitation that complies with subsections (d)  
20 and (e) of Section 55 of the Prior Authorization Reform  
21 Act, ~~if the plan provides that the beneficiary will incur~~  
22 ~~a penalty for failing to pre-certify inpatient hospital~~  
23 ~~treatment, the penalty may not exceed \$1,000 per~~  
24 ~~occurrence in addition to the plan cost sharing~~  
25 ~~provisions.~~

26 (9) For a network plan to be offered through the

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

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

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

- 21 (A) Primary Care;
- 22 (B) Pediatrics;
- 23 (C) Cardiology;
- 24 (D) Gastroenterology;
- 25 (E) General Surgery;
- 26 (F) Neurology;

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

24 (1.5) Beginning January 1, 2026, every issuer shall  
25 demonstrate to the Director that each in-network hospital  
26 has at least one radiologist, pathologist,

1       anesthesiologist, and emergency room physician as a  
2       preferred provider in a network plan. The Department may,  
3       by rule, require additional types of hospital-based  
4       medical specialists to be included as preferred providers  
5       in each in-network hospital in a network plan.

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

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

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

1        Services establishes minimum provider ratios for  
2        stand-alone dental plans in the type of exchange in use in  
3        this State for a given plan year, the Department shall  
4        enforce those standards for stand-alone dental plans for  
5        that plan year.

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

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

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

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

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

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

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

1 and distance standards for stand-alone dental plans in the  
2 type of exchange in use in this State for a given plan year,  
3 the Department shall enforce those standards for stand-alone  
4 dental plans for that plan year.

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

1 following requirements:

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

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

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

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

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

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

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

26 (e) Except for network plans solely offered as a group

1 health plan, these ratio and time and distance standards apply  
2 to the lowest cost-sharing tier of any tiered network.

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

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

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

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

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

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

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

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

1 received from that provider type within that county at the  
2 in-network benefit level and shall retroactively adjudicate  
3 and reimburse beneficiaries to achieve that objective if their  
4 claims were processed at the out-of-network level contrary to  
5 this subsection. Nothing in this subsection shall be construed  
6 to supersede Section 356z.3a of the Illinois Insurance Code.

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

23 (k) For the Department to enforce any new or modified  
24 federal standard before the Department adopts the standard by  
25 rule, the Department must, no later than May 15 before the  
26 start of the plan year, give public notice to the affected

1 health insurance issuers through a bulletin.

2 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
3 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

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

5 Sec. 10. Network adequacy.

6 (a) Before issuing, delivering, or renewing a network  
7 plan, an issuer ~~An insurer~~ providing a network plan shall file  
8 a description of all of the following with the Director:

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

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

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

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

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

4 (b) Before issuing, delivering, or renewing a network  
5 plan, an issuer ~~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 in each  
20 plan, additional information about the plan, as well as  
21 any 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 complies with subsections (d)  
4 and (e) of Section 55 of the Prior Authorization Reform  
5 Act.

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

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

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

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

1 (AA) Pediatric Specialty Services;

2 (BB) Outpatient Dialysis; and

3 (CC) HIV.

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

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

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

1 guidance. If the Centers for Medicare and Medicaid  
2 Services establish standards that are more stringent than  
3 the standards in effect under any Department rule, the  
4 Department may amend its rules to conform to the more  
5 stringent federal standards.

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

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

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

25 The Director shall establish a process for the review of  
26 the adequacy of these standards along with an assessment of

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

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

19 If the federal area designations for the maximum time or  
20 distance or appointment wait-time standards required are  
21 changed by the most recent Letter to Issuers in the  
22 Federally-facilitated Marketplaces, the Department shall post  
23 on its website notice of such changes and may amend its rules  
24 to conform to those designations if the Director deems  
25 appropriate.

26 If the federal Centers for Medicare and Medicaid Services

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

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

1 requirements of Section 370c.1 of the Illinois Insurance Code  
2 and the federal Paul Wellstone and Pete Domenici Mental Health  
3 Parity and Addiction Equity Act of 2008. Notwithstanding the  
4 foregoing, the network adequacy standards for timely and  
5 proximate access to treatment for mental, emotional, nervous,  
6 or substance use disorders or conditions shall, at a minimum,  
7 satisfy the 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 ~~insurer~~ shall provide necessary exceptions to its  
13 network to ensure admission and treatment with a provider or  
14 at a treatment facility in accordance with the network  
15 adequacy 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 (5) If the federal Centers for Medicare and Medicaid  
25 Services establishes a more stringent standard in any county  
26 than specified in paragraph (1) or (2) of this subsection

1 (d-5) for qualified health plans in the type of exchange in use  
2 in this State for a given plan year, the federal standard shall  
3 apply in lieu of the standard in paragraph (1) or (2) of this  
4 subsection (d-5) for qualified health plans for that plan  
5 year.

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

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

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

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

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

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

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

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

1 a revised network adequacy filing to the Director, the  
2 Director may order a fine of \$5,000 per day.

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

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

1 a material change. Policies or certificates issued or renewed  
2 in violation of this subsection may subject the issuer to a  
3 civil penalty of \$5,000 per policy.

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

9 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
10 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

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

12 Sec. 10. Network adequacy.

13 (a) Before issuing, delivering, or renewing a network  
14 plan, an issuer ~~An insurer~~ providing a network plan shall file  
15 a description of all of the following with the Director:

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

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

23 (3) The written policies and procedures on how the  
24 network plan will provide 24-hour, 7-day per week access  
25 to network-affiliated primary care, emergency services,

1 and obstetrical and gynecological health care  
2 professionals.

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) Before issuing, delivering, or renewing a network  
12 plan, an issuer ~~Insurers~~ must file for review a description of  
13 the services to be offered through a network plan. The  
14 description shall include all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (8) A limitation that complies with subsections (d)  
11 and (e) of Section 55 of the Prior Authorization Reform  
12 Act, ~~if the plan provides that the beneficiary will incur~~  
13 ~~a penalty for failing to pre-certify inpatient hospital~~  
14 ~~treatment, the penalty may not exceed \$1,000 per~~  
15 ~~occurrence in addition to the plan cost sharing~~  
16 ~~provisions.~~

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

24 (c) The issuer ~~network plan~~ shall demonstrate to the  
25 Director a minimum ratio of providers to plan beneficiaries as  
26 required by the Department for each network plan.

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

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

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

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

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

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

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

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

22 (d-5) (1) Every issuer ~~insurer~~ shall ensure that  
23 beneficiaries have timely and proximate access to treatment  
24 for mental, emotional, nervous, or substance use disorders or  
25 conditions in accordance with the provisions of paragraph (4)  
26 of subsection (a) of Section 370c of the Illinois Insurance

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

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

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

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

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

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

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

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

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

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

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

25 (j) If the Director determines that a network is  
26 inadequate in any county and no exception has been granted

1 under subsection (g) and the issuer does not have a process in  
2 place to comply with subsection (d-5), the Director may  
3 prohibit the network plan from being issued or renewed within  
4 that county until the Director determines that the network is  
5 adequate apart from processes and exceptions described in  
6 subsections (d-5) and (g). Nothing in this subsection shall be  
7 construed to terminate any beneficiary's health insurance  
8 coverage under a network plan before the expiration of the  
9 beneficiary's policy period if the Director makes a  
10 determination under this subsection after the issuance or  
11 renewal of the beneficiary's policy or certificate because of  
12 a material change. Policies or certificates issued or renewed  
13 in violation of this subsection may subject the issuer to a  
14 civil penalty of \$5,000 per policy.

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

20 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
21 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

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

23 Sec. 10. Network adequacy.

24 (a) Before issuing, delivering, or renewing a network  
25 plan, an issuer ~~An insurer~~ providing a network plan shall file

1 a description of all of the following with the Director:

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

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

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

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

22 (b) Before issuing, delivering, or renewing a network  
23 plan, an issuer ~~Insurers~~ must file for review a description of  
24 the services to be offered through a network plan. The  
25 description shall include all of the following:

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

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

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

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

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

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

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

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

26 (C) the travel and distance standards for plan

1 beneficiaries in county service areas; and

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

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

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

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

21 (8) A limitation that complies with subsections (d)  
22 and (e) of Section 55 of the Prior Authorization Reform  
23 Act, ~~if the plan provides that the beneficiary will incur~~  
24 ~~a penalty for failing to pre-certify inpatient hospital~~  
25 ~~treatment, the penalty may not exceed \$1,000 per~~  
26 ~~occurrence in addition to the plan cost sharing~~

1 ~~provisions.~~

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

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

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

- 23 (A) Primary Care;
- 24 (B) Pediatrics;
- 25 (C) Cardiology;
- 26 (D) Gastroenterology;

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

26 (1.5) Beginning January 1, 2026, every issuer shall

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

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

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

1       stringent federal standards.

2           (4) ~~(3)~~ If the federal Centers for Medicare and  
3       Medicaid Services establishes minimum provider ratios for  
4       stand-alone dental plans in the type of exchange in use in  
5       this State for a given plan year, the Department shall  
6       enforce those standards for stand-alone dental plans for  
7       that plan year.

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

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

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

25           Notwithstanding any other law or Department rule, the  
26      maximum travel time and distance standards and appointment

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

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

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

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

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

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

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

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

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

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

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

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

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

1 year.

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

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

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

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

26 (2) if patterns of care in the service area do not

1 support the need for the requested number of provider or  
2 facility type and the issuer ~~insurer~~ provides data on  
3 local patterns of care, such as claims data, referral  
4 patterns, or local provider interviews, indicating where  
5 the beneficiaries currently seek this type of care or  
6 where the physicians currently refer beneficiaries, or  
7 both; or

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

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

25 (i) If a network plan is inadequate under this Act with  
26 respect to a provider type in a county, and if the network plan

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

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

26 (k) For the Department to enforce any new or modified

1 federal standard before the Department adopts the standard by  
2 rule, the Department must, no later than May 15 before the  
3 start of the plan year, give public notice to the affected  
4 health insurance issuers through a bulletin.

5 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
6 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

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

8 Sec. 10. Network adequacy.

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

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

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

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

24 An issuer ~~insurer~~ shall not prohibit a preferred provider  
25 from discussing any specific or all treatment options with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (8) A limitation that complies with subsections (d)  
7 and (e) of Section 55 of the Prior Authorization Reform  
8 Act, ~~if the plan provides that the beneficiary will incur~~  
9 ~~a penalty for failing to pre-certify inpatient hospital~~  
10 ~~treatment, the penalty may not exceed \$1,000 per~~  
11 ~~occurrence in addition to the plan cost sharing~~  
12 ~~provisions.~~

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

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

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

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

8 (A) Primary Care;

9 (B) Pediatrics;

10 (C) Cardiology;

11 (D) Gastroenterology;

12 (E) General Surgery;

13 (F) Neurology;

14 (G) OB/GYN;

15 (H) Oncology/Radiation;

16 (I) Ophthalmology;

17 (J) Urology;

18 (K) Behavioral Health;

19 (L) Allergy/Immunology;

20 (M) Chiropractic;

21 (N) Dermatology;

22 (O) Endocrinology;

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

24 (Q) Infectious Disease;

25 (R) Nephrology;

26 (S) Neurosurgery;

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

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

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

23 (3) Notwithstanding any other law or rule, the minimum  
24 ratio for each provider type shall be no less than any such  
25 ratio established for qualified health plans in  
26 Federally-Facilitated Exchanges by federal law or by the

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

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

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

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

26 If the federal area designations for the maximum time or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 grant an exception in the following circumstances:

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

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

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

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

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

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

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

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

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

16 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
17 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

18 (215 ILCS 124/25)

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

20 Sec. 25. Network transparency.

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

25 (1) In making the directory available electronically,

1 the network plans shall ensure that the general public is  
2 able to view all of the current providers for a plan  
3 through a clearly identifiable link or tab and without  
4 creating or accessing an account or entering a policy or  
5 contract number.

6 (2) An issuer's failure to update a network plan's  
7 directory shall subject the issuer to a civil penalty of  
8 \$5,000 per month. The network plan shall update the online  
9 provider directory at least monthly. Providers shall  
10 notify the network plan electronically or in writing  
11 within 10 business days of any changes to their  
12 information as listed in the provider directory, including  
13 the information required in subsections (b), (c), and (d)  
14 subparagraph (K) of paragraph (1) of subsection (b). With  
15 regard to subparagraph (I) of paragraph (1) of subsection  
16 (b), the provider must give notice to the issuer within 20  
17 business days of deciding to cease accepting new patients  
18 covered by the plan if the new patient limitation is  
19 expected to last 40 business days or longer. The network  
20 plan shall update its online provider directory in a  
21 manner consistent with the information provided by the  
22 provider within 2 ~~10~~ business days after being notified of  
23 the change by the provider. Nothing in this paragraph (2)  
24 shall void any contractual relationship between the  
25 provider and the plan.

26 (3) At least once every 90 days, the issuer shall

1        self-audit each network plan's ~~The network plan shall~~  
2        ~~audit periodically at least 25% of its~~ provider  
3        directories for accuracy, make any corrections necessary,  
4        and retain documentation of the audit. The issuer shall  
5        submit the self-audit and a summary to the Department, and  
6        the Department shall make the summary of each self-audit  
7        publicly available. The Department shall specify the  
8        requirements of the summary, which shall be statistical in  
9        nature except for a high-level narrative evaluating the  
10       impact of internal and external factors on the accuracy of  
11       the directory and the timeliness of updates. ~~The network~~  
12       ~~plan shall submit the audit to the Director upon request.~~  
13       As part of these self-audits ~~audits~~, the network plan  
14       shall contact any provider in its network that has not  
15       submitted a claim to the plan or otherwise communicated  
16       his or her intent to continue participation in the plan's  
17       network. The self-audits shall comply with 42 U.S.C.  
18       300gg-115(a)(2), except that "provider directory  
19       information" shall include all information required to be  
20       included in a provider directory pursuant to this Act.

21       (4) A network plan shall provide a printed copy of a  
22       current provider directory or a printed copy of the  
23       requested directory information upon request of a  
24       beneficiary or a prospective beneficiary. Except when an  
25       issuer's printed copies use the same provider information  
26       as the electronic provider directory on each printed

1 copy's date of printing, printed ~~Printed~~ copies must be  
2 updated at least every 90 days ~~quarterly~~ and ~~an~~ errata  
3 that reflects changes in the provider network must be  
4 included in each update ~~updated quarterly~~.

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

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

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

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

23 (D) if applicable, a notation that authorization  
24 or referral may be required to access some providers; ~~i-~~

25 (E) a telephone number and email address for a  
26 customer service representative to whom directory

1           inaccuracies may be reported; and

2           (F) a detailed description of the process to  
3           dispute charges for out-of-network providers,  
4           hospitals, or facilities that were incorrectly listed  
5           as in-network prior to the provision of care and a  
6           telephone number and email address to dispute such  
7           charges.

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

19          (7) A provider directory, whether in electronic or  
20          print format, shall accommodate the communication needs of  
21          individuals with disabilities, and include a link to or  
22          information regarding available assistance for persons  
23          with limited English proficiency.

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

1 (1) for health care professionals:

2 (A) name;

3 (B) gender;

4 (C) participating office locations;

5 (D) patient population served (such as pediatric,  
6 adult, elderly, or women) and specialty or  
7 subspecialty, if applicable;

8 (E) medical group affiliations, if applicable;

9 (F) facility affiliations, if applicable;

10 (G) participating facility affiliations, if  
11 applicable;

12 (H) languages spoken other than English, if  
13 applicable;

14 (I) whether accepting new patients;

15 (J) board certifications, if applicable; ~~and~~

16 (K) 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 (L) whether the health care professional  
5 accepts appointment requests from patients; and

6 (M) the anticipated date the provider will  
7 leave the network, if applicable, which shall be  
8 included no more than 10 days after the issuer  
9 confirms that the provider is scheduled to leave  
10 the network;

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 (E) the anticipated date the hospital will leave  
18 the network, if applicable, which shall be included no  
19 more than 10 days after the issuer confirms the  
20 hospital is scheduled to leave the network; and

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

22 (A) facility name;

23 (B) facility type;

24 (C) types of services performed; ~~and~~

25 (D) participating facility location or locations;

26 and-

1           (E) the anticipated date the facility will leave  
2           the network, if applicable, which shall be included no  
3           more than 10 days after the issuer confirms the  
4           facility is scheduled to leave the network.

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

9           (1) for health care professionals:

10           (A) contact information, including both a  
11           telephone number and digital contact information if  
12           the provider has supplied digital contact information;

13           and

14           (B) languages spoken other than English by  
15           clinical staff, if applicable;

16           (2) for hospitals, telephone number and digital  
17           contact information; and

18           (3) for facilities other than hospitals, telephone  
19           number.

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

23           (1) for health care professionals:

24           (A) name;

25           (B) contact information, including a telephone  
26           number and digital contact information if the provider

1           has supplied digital contact information;

2           (C) participating office location or locations;

3           (D) patient population (such as pediatric, adult,  
4 elderly, or women) and specialty or subspecialty, if  
5 applicable;

6           (E) languages spoken other than English, if  
7 applicable;

8           (F) whether accepting new patients; ~~and~~

9           (G) use of telehealth or telemedicine, including,  
10 but not limited to:

11           (i) whether the provider offers the use of  
12 telehealth or telemedicine to deliver services to  
13 patients for whom it would be clinically  
14 appropriate;

15           (ii) what modalities are used and what types  
16 of services may be provided via telehealth or  
17 telemedicine; and

18           (iii) whether the provider has the ability and  
19 willingness to include in a telehealth or  
20 telemedicine encounter a family caregiver who is  
21 in a separate location than the patient if the  
22 patient wishes and provides his or her consent;  
23 and

24           (H) whether the health care professional accepts  
25 appointment requests from patients;

26           (2) for hospitals:

- 1 (A) hospital name;
- 2 (B) hospital type (such as acute, rehabilitation,  
3 children's, or cancer); and
- 4 (C) participating hospital location, ~~and~~ telephone  
5 number, and digital contact information; and
- 6 (3) for facilities, other than hospitals, by type:
- 7 (A) facility name;
- 8 (B) facility type;
- 9 (C) patient population (such as pediatric, adult,  
10 elderly, or women) served, if applicable, and types of  
11 services performed; and
- 12 (D) participating facility location or locations,  
13 ~~and~~ telephone numbers, and digital contact information  
14 for each location.
- 15 (e) The network plan shall include a disclosure in the  
16 print format provider directory that the information included  
17 in the directory is accurate as of the date of printing and  
18 that beneficiaries or prospective beneficiaries should consult  
19 the issuer's ~~insurer's~~ electronic provider directory on its  
20 website and contact the provider. The network plan shall also  
21 include a telephone number and email address in the print  
22 format provider directory for a customer service  
23 representative where the beneficiary can obtain current  
24 provider directory information or report provider directory  
25 inaccuracies. The printed provider directory shall include a  
26 detailed description of the process to dispute charges for

1 out-of-network providers, hospitals, or facilities that were  
2 incorrectly listed as in-network prior to the provision of  
3 care and a telephone number and email address to dispute those  
4 charges.

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

10 (g) To the extent not otherwise provided in this Act, an  
11 issuer shall comply with the requirements of 42 U.S.C.  
12 300gg-115, except that "provider directory information" shall  
13 include all information required to be included in a provider  
14 directory pursuant to this Section.

15 (h) If the issuer or the Department identifies a provider  
16 incorrectly listed in the provider directory, the issuer shall  
17 check each of the issuer's network plan provider directories  
18 for the provider within 2 business days to ascertain whether  
19 the provider is a preferred provider in that network plan and,  
20 if the provider is incorrectly listed in the provider  
21 directory, remove the provider from the provider directory  
22 without delay.

23 (i) If the Director determines that an issuer violated  
24 this Section, the Director may assess a fine up to \$5,000 per  
25 violation, except for inaccurate information given by a  
26 provider to the issuer. If an issuer, or any entity or person

1 acting on the issuer's behalf, knew or reasonably should have  
2 known that a provider was incorrectly included in a provider  
3 directory, the Director may assess a fine of up to \$25,000 per  
4 violation against the issuer.

5 (j) This Section applies to network plans not otherwise  
6 exempt under Section 3.

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

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

9 Sec. 25. Network transparency.

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

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

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

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

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

1 self-audits shall comply with 42 U.S.C. 300gg-115(a)(2),  
2 except that "provider directory information" shall include  
3 all information required to be included in a provider  
4 directory pursuant to this Act.

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

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

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

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

24 (C) if applicable, in plain language, how the  
25 network plan designates the different provider tiers  
26 or levels in the network and identifies for each

1 specific provider, hospital, or other type of facility  
2 in the network which tier each is placed, for example,  
3 by name, symbols, or grouping, in order for a  
4 beneficiary-covered person or a prospective  
5 beneficiary-covered person to be able to identify the  
6 provider tier;

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

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

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

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

1 and contact information for the Department's Office of  
2 Consumer Health Insurance.

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

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

11 (1) for health care professionals:

12 (A) name;

13 (B) gender;

14 (C) participating office locations;

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

18 (E) medical group affiliations, if applicable;

19 (F) facility affiliations, if applicable;

20 (G) participating facility affiliations, if  
21 applicable;

22 (H) languages spoken other than English, if  
23 applicable;

24 (I) whether accepting new patients;

25 (J) board certifications, if applicable;

26 (K) use of telehealth or telemedicine, including,

1 but not limited to:

2 (i) whether the provider offers the use of  
3 telehealth or telemedicine to deliver services to  
4 patients for whom it would be clinically  
5 appropriate;

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

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

14 (L) whether the health care professional accepts  
15 appointment requests from patients; and

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

20 (2) for hospitals:

21 (A) hospital name;

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

24 (C) participating hospital location;

25 (D) hospital accreditation status; and

26 (E) the anticipated date the hospital will leave

1 the network, if applicable, which shall be included no  
2 more than 10 days after the issuer confirms the  
3 hospital is scheduled to leave the network; and

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

5 (A) facility name;

6 (B) facility type;

7 (C) types of services performed;

8 (D) participating facility location or locations;

9 and

10 (E) the anticipated date the facility will leave  
11 the network, if applicable, which shall be included no  
12 more than 10 days after the issuer confirms the  
13 facility is scheduled to leave the network.

14 (c) For the electronic provider directories, for each  
15 network plan, a network plan shall make available all of the  
16 following information in addition to the searchable  
17 information required in this Section:

18 (1) for health care professionals:

19 (A) contact information, including both a  
20 telephone number and digital contact information if  
21 the provider has supplied digital contact information;  
22 and

23 (B) languages spoken other than English by  
24 clinical staff, if applicable;

25 (2) for hospitals, telephone number and digital  
26 contact information; and

1           (3) for facilities other than hospitals, telephone  
2           number.

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

6           (1) for health care professionals:

7           (A) name;

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

11          (C) participating office location or locations;

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

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

17          (F) whether accepting new patients;

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 and

7 (H) whether the health care professional accepts  
8 appointment requests from patients;

9 (2) for hospitals:

10 (A) hospital name;

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

13 (C) participating hospital location, telephone  
14 number, and digital contact information; and

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

16 (A) facility name;

17 (B) facility type;

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

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

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

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

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

24 (h) If the issuer or the Department identifies a provider  
25 incorrectly listed in the provider directory, the issuer shall  
26 check each of the issuer's network plan provider directories

1 for the provider within 2 business days to ascertain whether  
2 the provider is a preferred provider in that network plan and,  
3 if the provider is incorrectly listed in the provider  
4 directory, remove the provider from the provider directory  
5 without delay.

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

14 (j) This Section applies to network plans not otherwise  
15 exempt under Section 3, ~~including stand alone dental plans.~~

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

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

18 Sec. 25. Network transparency.

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

23 (1) In making the directory available electronically,  
24 the network plans shall ensure that the general public is  
25 able to view all of the current providers for a plan

1 through a clearly identifiable link or tab and without  
2 creating or accessing an account or entering a policy or  
3 contract number.

4 (2) An issuer's failure to update a network plan's  
5 directory shall subject the issuer to a civil penalty of  
6 \$5,000 per month. ~~The network plan shall update the online~~  
7 ~~provider directory at least monthly.~~ Providers shall  
8 notify the network plan electronically or in writing  
9 within 10 business days of any changes to their  
10 information as listed in the provider directory, including  
11 the information required in subsections (b), (c), and (d)  
12 ~~subparagraph (K) of paragraph (1) of subsection (b).~~ With  
13 regard to subparagraph (I) of paragraph (1) of subsection  
14 (b), the provider must give notice to the issuer within 20  
15 business days of deciding to cease accepting new patients  
16 covered by the plan if the new patient limitation is  
17 expected to last 40 business days or longer. The network  
18 plan shall update its online provider directory in a  
19 manner consistent with the information provided by the  
20 provider within 2 ~~10~~ business days after being notified of  
21 the change by the provider. Nothing in this paragraph (2)  
22 shall void any contractual relationship between the  
23 provider and the plan.

24 (3) At least once every 90 days, the issuer shall  
25 self-audit each network plan's ~~The network plan shall~~  
26 ~~audit periodically at least 25% of its~~ provider

1 directories for accuracy, make any corrections necessary,  
2 and retain documentation of the audit. The issuer shall  
3 submit the self-audit and a summary to the Department, and  
4 the Department shall make the summary of each self-audit  
5 publicly available. The Department shall specify the  
6 requirements of the summary, which shall be statistical in  
7 nature except for a high-level narrative evaluating the  
8 impact of internal and external factors on the accuracy of  
9 the directory and the timeliness of updates. ~~The network~~  
10 plan shall submit the audit to the Director upon request.  
11 As part of these self-audits ~~audits~~, the network plan  
12 shall contact any provider in its network that has not  
13 submitted a claim to the plan or otherwise communicated  
14 his or her intent to continue participation in the plan's  
15 network. The self-audits shall comply with 42 U.S.C.  
16 300gg-115(a)(2), except that "provider directory  
17 information" shall include all information required to be  
18 included in a provider directory pursuant to this Act.

19 (4) A network plan shall provide a printed copy of a  
20 current provider directory or a printed copy of the  
21 requested directory information upon request of a  
22 beneficiary or a prospective beneficiary. Except when an  
23 issuer's printed copies use the same provider information  
24 as the electronic provider directory on each printed  
25 copy's date of printing, printed ~~Printed~~ copies must be  
26 updated at least every 90 days ~~quarterly~~ and an errata

1 that reflects changes in the provider network must be  
2 included in each update ~~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 (E) a telephone number and email address for a  
24 customer service representative to whom directory  
25 inaccuracies may be reported; and

26 (F) a detailed description of the process to

1           dispute charges for out-of-network providers,  
2           hospitals, or facilities that were incorrectly listed  
3           as in-network prior to the provision of care and a  
4           telephone number and email address to dispute such  
5           charges.

6           (6) A network plan shall make it clear for both its  
7           electronic and print directories what provider directory  
8           applies to which network plan, such as including the  
9           specific name of the network plan as marketed and issued  
10          in this State. The network plan shall include in both its  
11          electronic and print directories a customer service email  
12          address and telephone number or electronic link that  
13          beneficiaries or the general public may use to notify the  
14          network plan of inaccurate provider directory information  
15          and contact information for the Department's Office of  
16          Consumer Health Insurance.

17          (7) A provider directory, whether in electronic or  
18          print format, shall accommodate the communication needs of  
19          individuals with disabilities, and include a link to or  
20          information regarding available assistance for persons  
21          with limited English proficiency.

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

25                  (1) for health care professionals:

26                          (A) name;

- 1 (B) gender;
- 2 (C) participating office locations;
- 3 (D) patient population served (such as pediatric,  
4 adult, elderly, or women) and specialty or  
5 subspecialty, if applicable;
- 6 (E) medical group affiliations, if applicable;
- 7 (F) facility affiliations, if applicable;
- 8 (G) participating facility affiliations, if  
9 applicable;
- 10 (H) languages spoken other than English, if  
11 applicable;
- 12 (I) whether accepting new patients;
- 13 (J) board certifications, if applicable; ~~and~~
- 14 (K) use of telehealth or telemedicine, including,  
15 but not limited to:
- 16 (i) whether the provider offers the use of  
17 telehealth or telemedicine to deliver services to  
18 patients for whom it would be clinically  
19 appropriate;
- 20 (ii) what modalities are used and what types  
21 of services may be provided via telehealth or  
22 telemedicine; and
- 23 (iii) whether the provider has the ability and  
24 willingness to include in a telehealth or  
25 telemedicine encounter a family caregiver who is  
26 in a separate location than the patient if the

1 patient wishes and provides his or her consent;

2 (L) whether the health care professional  
3 accepts appointment requests from patients; and

4 (M) the anticipated date the provider will  
5 leave the network, if applicable, which shall be  
6 included no more than 10 days after the issuer  
7 confirms that the provider is scheduled to leave  
8 the network;

9 (2) for hospitals:

10 (A) hospital name;

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

13 (C) participating hospital location; ~~and~~

14 (D) hospital accreditation status; and

15 (E) the anticipated date the hospital will leave  
16 the network, if applicable, which shall be included no  
17 more than 10 days after the issuer confirms the  
18 hospital is scheduled to leave the network; and

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

20 (A) facility name;

21 (B) facility type;

22 (C) types of services performed; ~~and~~

23 (D) participating facility location or locations;  
24 and-

25 (E) the anticipated date the facility will leave  
26 the network, if applicable, which shall be included no

1           more than 10 days after the issuer confirms the  
2           facility is scheduled to leave the network.

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

7           (1) for health care professionals:

8           (A) contact information, including both a  
9           telephone number and digital contact information if  
10           the provider has supplied digital contact information;

11           and

12           (B) languages spoken other than English by  
13           clinical staff, if applicable;

14           (2) for hospitals, telephone number and digital  
15           contact information; and

16           (3) for facilities other than hospitals, telephone  
17           number.

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

21           (1) for health care professionals:

22           (A) name;

23           (B) contact information, including a telephone  
24           number and digital contact information if the provider  
25           has supplied digital contact information;

26           (C) participating office location or locations;

1 (D) patient population (such as pediatric, adult,  
2 elderly, or women) and specialty or subspecialty, if  
3 applicable;

4 (E) languages spoken other than English, if  
5 applicable;

6 (F) whether accepting new patients; ~~and~~

7 (G) use of telehealth or telemedicine, including,  
8 but not limited to:

9 (i) whether the provider offers the use of  
10 telehealth or telemedicine to deliver services to  
11 patients for whom it would be clinically  
12 appropriate;

13 (ii) what modalities are used and what types  
14 of services may be provided via telehealth or  
15 telemedicine; and

16 (iii) whether the provider has the ability and  
17 willingness to include in a telehealth or  
18 telemedicine encounter a family caregiver who is  
19 in a separate location than the patient if the  
20 patient wishes and provides his or her consent;  
21 and

22 (H) whether the health care professional accepts  
23 appointment requests from patients;

24 (2) for hospitals:

25 (A) hospital name;

26 (B) hospital type (such as acute, rehabilitation,

1 children's, or cancer); and

2 (C) participating hospital location, ~~and~~ telephone  
3 number, and digital contact information; and

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

5 (A) facility name;

6 (B) facility type;

7 (C) patient population (such as pediatric, adult,  
8 elderly, or women) served, if applicable, and types of  
9 services performed; and

10 (D) participating facility location or locations, ~~and~~  
11 telephone numbers, and digital contact information  
12 for each location.

13 (e) The network plan shall include a disclosure in the  
14 print format provider directory that the information included  
15 in the directory is accurate as of the date of printing and  
16 that beneficiaries or prospective beneficiaries should consult  
17 the issuer's ~~insurer's~~ electronic provider directory on its  
18 website and contact the provider. The network plan shall also  
19 include a telephone number and email address in the print  
20 format provider directory for a customer service  
21 representative where the beneficiary can obtain current  
22 provider directory information or report provider directory  
23 inaccuracies. The printed provider directory shall include a  
24 detailed description of the process to dispute charges for  
25 out-of-network providers, hospitals, or facilities that were  
26 incorrectly listed as in-network prior to the provision of

1 care and a telephone number and email address to dispute those  
2 charges.

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

8 (g) To the extent not otherwise provided in this Act, an  
9 issuer shall comply with the requirements of 42 U.S.C.  
10 300gg-115, except that "provider directory information" shall  
11 include all information required to be included in a provider  
12 directory pursuant to this Section.

13 (h) If the issuer or the Department identifies a provider  
14 incorrectly listed in the provider directory, the issuer shall  
15 check each of the issuer's network plan provider directories  
16 for the provider within 2 business days to ascertain whether  
17 the provider is a preferred provider in that network plan and,  
18 if the provider is incorrectly listed in the provider  
19 directory, remove the provider from the provider directory  
20 without delay.

21 (i) If the Director determines that an issuer violated  
22 this Section, the Director may assess a fine up to \$5,000 per  
23 violation, except for inaccurate information given by a  
24 provider to the issuer. If an issuer, or any entity or person  
25 acting on the issuer's behalf, knew or reasonably should have  
26 known that a provider was incorrectly included in a provider

1 directory, the Director may assess a fine of up to \$25,000 per  
2 violation against the issuer.

3 (j) ~~(g)~~ This Section applies to network plans that are not  
4 otherwise exempt under Section 3, including stand-alone dental  
5 plans that are subject to provider directory requirements  
6 under federal law.

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

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

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

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

12 Sec. 5-3. Insurance Code provisions.

13 (a) Health Maintenance Organizations shall be subject to  
14 the provisions of Sections 133, 134, 136, 137, 139, 140,  
15 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,  
16 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,  
17 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g.5-1,  
18 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a,  
19 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,  
20 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18,  
21 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25,  
22 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33,  
23 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40,  
24 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47,

1 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55,  
2 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62,  
3 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69,  
4 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76,  
5 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,  
6 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,  
7 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)  
8 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,  
9 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the  
10 Illinois Insurance Code.

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

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

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

19 (3) a corporation organized under the laws of another  
20 state, 30% or more of the enrollees of which are residents  
21 of this State, except a corporation subject to  
22 substantially the same requirements in its state of  
23 organization as is a "domestic company" under Article VIII  
24 1/2 of the Illinois Insurance Code.

25 (c) In considering the merger, consolidation, or other  
26 acquisition of control of a Health Maintenance Organization

1 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

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

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

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

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

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

26 (C) a pro forma business plan detailing an

1           acquiring party's plans with respect to the operation  
2           of the Health Maintenance Organization sought to be  
3           acquired for a period of not less than 3 years; and

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

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

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

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

1 group or other enrollment unit to effect refunds or charge  
2 additional premiums under the following terms and conditions:

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

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

24 The Health Maintenance Organization shall include a  
25 statement in the evidence of coverage issued to each enrollee  
26 describing the possibility of a refund or additional premium,

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

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

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

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

1 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.  
2 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,  
3 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;  
4 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.  
5 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,  
6 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;  
7 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.  
8 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

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

10 Sec. 5-3. Insurance Code provisions.

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

1 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,  
2 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5,  
3 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,  
4 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,  
5 paragraph (c) of subsection (2) of Section 367, and Articles  
6 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and  
7 XXXIIB of the Illinois Insurance Code.

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

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

14 (2) a corporation organized under the laws of this  
15 State; or

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

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

25 (1) the Director shall give primary consideration to  
26 the continuation of benefits to enrollees and the

1 financial conditions of the acquired Health Maintenance  
2 Organization after the merger, consolidation, or other  
3 acquisition of control takes effect;

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

11 (3) the Director shall have the power to require the  
12 following information:

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

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

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

1           (D) such other information as the Director shall  
2           require.

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

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

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

26                 (i) the amount of, and other terms and conditions with

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

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

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

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

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

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

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

1 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.  
2 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,  
3 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;  
4 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.  
5 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised  
6 11-26-24.)

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

9 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

10 Sec. 4003. Illinois Insurance Code provisions. Limited  
11 health service organizations shall be subject to the  
12 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,  
13 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153,  
14 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c,  
15 355.2, 355.3, 355b, 355d, 356m, 356q, 356v, 356z.4, 356z.4a,  
16 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.32,  
17 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54,  
18 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 356z.71,  
19 356z.73, 356z.74, 356z.75, 364.3, 368a, 401, 401.1, 402, 403,  
20 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA,  
21 VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, ~~and~~ XXVI, and  
22 XXXIIB of the Illinois Insurance Code. Nothing in this Section  
23 shall require a limited health care plan to cover any service  
24 that is not a limited health service. For purposes of the

1 Illinois Insurance Code, except for Sections 444 and 444.1 and  
2 Articles XIII and XIII 1/2, limited health service  
3 organizations in the following categories are deemed to be  
4 domestic companies:

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

6 (2) a corporation organized under the laws of another  
7 state, 30% or more of the enrollees of which are residents  
8 of this State, except a corporation subject to  
9 substantially the same requirements in its state of  
10 organization as is a domestic company under Article VIII  
11 1/2 of the Illinois Insurance Code.

12 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;  
13 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.  
14 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,  
15 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;  
16 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.  
17 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,  
18 eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25;  
19 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff.  
20 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832,  
21 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

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

24 (720 ILCS 5/17-0.5)

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

2           "Altered credit card or debit card" means any instrument  
3 or device, whether known as a credit card or debit card, which  
4 has been changed in any respect by addition or deletion of any  
5 material, except for the signature by the person to whom the  
6 card is issued.

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

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

15          "Computer network" means a set of related, remotely  
16 connected devices and any communications facilities including  
17 more than one computer with the capability to transmit data  
18 between them through the communications facilities.

19          "Computer program" or "program" means a series of coded  
20 instructions or statements in a form acceptable to a computer  
21 which causes the computer to process data and supply the  
22 results of the data processing.

23          "Computer services" means computer time or services,  
24 including data processing services, Internet services,  
25 electronic mail services, electronic message services, or  
26 information or data stored in connection therewith.

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

4 "Credit card" means any instrument or device, whether  
5 known as a credit card, credit plate, charge plate or any other  
6 name, issued with or without fee by an issuer for the use of  
7 the cardholder in obtaining money, goods, services or anything  
8 else of value on credit or in consideration or an undertaking  
9 or guaranty by the issuer of the payment of a check drawn by  
10 the cardholder.

11 "Data" means a representation in any form of information,  
12 knowledge, facts, concepts, or instructions, including program  
13 documentation, which is prepared or has been prepared in a  
14 formalized manner and is stored or processed in or transmitted  
15 by a computer or in a system or network. Data is considered  
16 property and may be in any form, including, but not limited to,  
17 printouts, magnetic or optical storage media, punch cards, or  
18 data stored internally in the memory of the computer.

19 "Debit card" means any instrument or device, known by any  
20 name, issued with or without fee by an issuer for the use of  
21 the cardholder in obtaining money, goods, services, and  
22 anything else of value, payment of which is made against funds  
23 previously deposited by the cardholder. A debit card which  
24 also can be used to obtain money, goods, services and anything  
25 else of value on credit shall not be considered a debit card  
26 when it is being used to obtain money, goods, services or

1 anything else of value on credit.

2 "Document" includes, but is not limited to, any document,  
3 representation, or image produced manually, electronically, or  
4 by computer.

5 "Electronic fund transfer terminal" means any machine or  
6 device that, when properly activated, will perform any of the  
7 following services:

8 (1) Dispense money as a debit to the cardholder's  
9 account; or

10 (2) Print the cardholder's account balances on a  
11 statement; or

12 (3) Transfer funds between a cardholder's accounts; or

13 (4) Accept payments on a cardholder's loan; or

14 (5) Dispense cash advances on an open end credit or a  
15 revolving charge agreement; or

16 (6) Accept deposits to a customer's account; or

17 (7) Receive inquiries of verification of checks and  
18 dispense information that verifies that funds are  
19 available to cover such checks; or

20 (8) Cause money to be transferred electronically from  
21 a cardholder's account to an account held by any business,  
22 firm, retail merchant, corporation, or any other  
23 organization.

24 "Electronic funds transfer system", hereafter referred to  
25 as "EFT System", means that system whereby funds are  
26 transferred electronically from a cardholder's account to any

1 other account.

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

6 "Expired credit card or debit card" means a credit card or  
7 debit card which is no longer valid because the term on it has  
8 elapsed.

9 "False academic degree" means a certificate, diploma,  
10 transcript, or other document purporting to be issued by an  
11 institution of higher learning or purporting to indicate that  
12 a person has completed an organized academic program of study  
13 at an institution of higher learning when the person has not  
14 completed the organized academic program of study indicated on  
15 the certificate, diploma, transcript, or other document.

16 "False claim" means any statement made to any insurer,  
17 purported insurer, servicing corporation, insurance broker, or  
18 insurance agent, or any agent or employee of one of those  
19 entities, and made as part of, or in support of, a claim for  
20 payment or other benefit under a policy of insurance, or as  
21 part of, or in support of, an application for the issuance of,  
22 or the rating of, any insurance policy, when the statement  
23 does any of the following:

24 (1) Contains any false, incomplete, or misleading  
25 information concerning any fact or thing material to the  
26 claim.

1           (2) Conceals (i) the occurrence of an event that is  
2 material to any person's initial or continued right or  
3 entitlement to any insurance benefit or payment or (ii)  
4 the amount of any benefit or payment to which the person is  
5 entitled.

6           "Financial institution" means any bank, savings and loan  
7 association, credit union, or other depository of money or  
8 medium of savings and collective investment.

9           "Governmental entity" means: each officer, board,  
10 commission, and agency created by the Constitution, whether in  
11 the executive, legislative, or judicial branch of State  
12 government; each officer, department, board, commission,  
13 agency, institution, authority, university, and body politic  
14 and corporate of the State; each administrative unit or  
15 corporate outgrowth of State government that is created by or  
16 pursuant to statute, including units of local government and  
17 their officers, school districts, and boards of election  
18 commissioners; and each administrative unit or corporate  
19 outgrowth of the foregoing items and as may be created by  
20 executive order of the Governor.

21           "Incomplete credit card or debit card" means a credit card  
22 or debit card which is missing part of the matter other than  
23 the signature of the cardholder which an issuer requires to  
24 appear on the credit card or debit card before it can be used  
25 by a cardholder, and this includes credit cards or debit cards  
26 which have not been stamped, embossed, imprinted or written

1 on.

2 "Institution of higher learning" means a public or private  
3 college, university, or community college located in the State  
4 of Illinois that is authorized by the Board of Higher  
5 Education or the Illinois Community College Board to issue  
6 post-secondary degrees, or a public or private college,  
7 university, or community college located anywhere in the  
8 United States that is or has been legally constituted to offer  
9 degrees and instruction in its state of origin or  
10 incorporation.

11 "Insurance company" means any "company" as defined under  
12 Section 2 of the Illinois Insurance Code, "dental service plan  
13 corporation" as defined in Section 3 of the Dental Service  
14 Plan Act, "health maintenance organization" as defined in  
15 Section 1-2 of the Health Maintenance Organization Act,  
16 "limited health service organization" as defined in Section  
17 1002 of the Limited Health Service Organization Act, "health  
18 services plan corporation" as defined in Section 2 of the  
19 Voluntary Health Services Plans Act, or any trust fund  
20 organized under the Religious and Charitable Risk Pooling  
21 Trust Act.

22 "Issuer" means the business organization or financial  
23 institution which issues a credit card or debit card, or its  
24 duly authorized agent.

25 "Merchant" has the meaning ascribed to it in Section  
26 16-0.1 of this Code.

1 "Person" means any individual, corporation, government,  
2 governmental subdivision or agency, business trust, estate,  
3 trust, partnership or association or any other entity.

4 "Receives" or "receiving" means acquiring possession or  
5 control.

6 "Record of charge form" means any document submitted or  
7 intended to be submitted to an issuer as evidence of a credit  
8 transaction for which the issuer has agreed to reimburse  
9 persons providing money, goods, property, services or other  
10 things of value.

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

14 "Sale" means any delivery for value.

15 "Scheme or artifice to defraud" includes a scheme or  
16 artifice to deprive another of the intangible right to honest  
17 services.

18 "Self-insured entity" means any person, business,  
19 partnership, corporation, or organization that sets aside  
20 funds to meet his, her, or its losses or to absorb fluctuations  
21 in the amount of loss, the losses being charged against the  
22 funds set aside or accumulated.

23 "Social networking website" means an Internet website  
24 containing profile web pages of the members of the website  
25 that include the names or nicknames of such members,  
26 photographs placed on the profile web pages by such members,

1 or any other personal or personally identifying information  
2 about such members and links to other profile web pages on  
3 social networking websites of friends or associates of such  
4 members that can be accessed by other members or visitors to  
5 the website. A social networking website provides members of  
6 or visitors to such website the ability to leave messages or  
7 comments on the profile web page that are visible to all or  
8 some visitors to the profile web page and may also include a  
9 form of electronic mail for members of the social networking  
10 website.

11 "Statement" means any assertion, oral, written, or  
12 otherwise, and includes, but is not limited to: any notice,  
13 letter, or memorandum; proof of loss; bill of lading; receipt  
14 for payment; invoice, account, or other financial statement;  
15 estimate of property damage; bill for services; diagnosis or  
16 prognosis; prescription; hospital, medical, or dental chart or  
17 other record, x-ray, photograph, videotape, or movie film;  
18 test result; other evidence of loss, injury, or expense;  
19 computer-generated document; and data in any form.

20 "Universal Price Code Label" means a unique symbol that  
21 consists of a machine-readable code and human-readable  
22 numbers.

23 "With intent to defraud" means to act knowingly, and with  
24 the specific intent to deceive or cheat, for the purpose of  
25 causing financial loss to another or bringing some financial  
26 gain to oneself, regardless of whether any person was actually

1 defrauded or deceived. This includes an intent to cause  
2 another to assume, create, transfer, alter, or terminate any  
3 right, obligation, or power with reference to any person or  
4 property.

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

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

13 Section 99. Effective date. This Act takes effect upon  
14 becoming law, except that the changes to Section 1563 of the  
15 Illinois Insurance Code take effect January 1, 2026, and the  
16 changes to Section 174 of the Illinois Insurance Code take  
17 effect 60 days after becoming law."