



Sen. Laura Fine

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LRB104 07006 BAB 24874 a

1 AMENDMENT TO SENATE BILL 708

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 708 by replacing  
3 everything after the enacting clause with the following:

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

7 (215 ILCS 5/355.7 new)

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

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

1 and payments of reinsurance, that such coverage expends:

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

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

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

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

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

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

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

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

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

22 (1) executive compensation beyond base salary;

23 (2) entity surplus or accumulated profit; or

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

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

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

8       (215 ILCS 5/356z.14)

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

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

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

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

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

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

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

1 utilizing benefits in this Section.

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

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

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

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

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

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

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

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

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

24    (i) As used in this Section:

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

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

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

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

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

1 medicine in all its branches:

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

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

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

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

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

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

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

8 (215 ILCS 5/356z.40)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Sec. 370c. Mental and emotional disorders.

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

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

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

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

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

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

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

1 ~~(t)~~.

2 (b) (1) (Blank).

3 (2) (Blank).

4 (2.5) (Blank).

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

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

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

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

7 (i) 45 days of inpatient treatment; and

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

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

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

22 (C) (Blank).

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

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

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

23 As used in this subsection:

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

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

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

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

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

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

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

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

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

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

15 (7) (Blank).

16 (8) (Blank).

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

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

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

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

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

1 operation, for medical and surgical benefits;

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

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

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

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

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

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

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

26 (e) Availability of plan information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 or

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

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

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

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

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

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

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

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

20 (h) As used in this Section:

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

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

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

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

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

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

1 treating physician, or other health care provider.

2 "Utilization review" means either of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 requirements of this Section.

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

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

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

26 (2) No policy shall require prior authorization for

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (215 ILCS 124/10)

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

10 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (A) Primary Care;

9 (B) Pediatrics;

10 (C) Cardiology;

11 (D) Gastroenterology;

12 (E) General Surgery;

13 (F) Neurology;

14 (G) OB/GYN;

15 (H) Oncology/Radiation;

16 (I) Ophthalmology;

17 (J) Urology;

18 (K) Behavioral Health;

19 (L) Allergy/Immunology;

20 (M) Chiropractic;

21 (N) Dermatology;

22 (O) Endocrinology;

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

24 (Q) Infectious Disease;

25 (R) Nephrology;

26 (S) Neurosurgery;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the physicians currently refer beneficiaries, or both; or

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

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

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

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

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

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

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

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

2 Sec. 10. Network adequacy.

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

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

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

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

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

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

1 shall include all of the following:

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

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

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

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

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

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

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

1 enrolled population;

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

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

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

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

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

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

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

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

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

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

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

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

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

1 or rural counties as defined by Department rule.

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

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

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

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

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

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

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

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

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

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

26 (B) Notwithstanding anything in this Section to the

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

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

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

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

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

1 or facility;

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

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

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

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

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

21 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 applicable.

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

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

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

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

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

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

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

8 (A) Primary Care;

9 (B) Pediatrics;

10 (C) Cardiology;

11 (D) Gastroenterology;

12 (E) General Surgery;

13 (F) Neurology;

14 (G) OB/GYN;

15 (H) Oncology/Radiation;

16 (I) Ophthalmology;

17 (J) Urology;

18 (K) Behavioral Health;

19 (L) Allergy/Immunology;

20 (M) Chiropractic;

21 (N) Dermatology;

22 (O) Endocrinology;

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

24 (Q) Infectious Disease;

25 (R) Nephrology;

26 (S) Neurosurgery;

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

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

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

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

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

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

1 following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
15 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

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

17 Sec. 10. Network adequacy.

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

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

25 (2) The written policies and procedures for making

1 referrals within and outside the network.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (7) A provision that the beneficiary shall receive

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

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

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

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

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

5 (A) Primary Care;

6 (B) Pediatrics;

7 (C) Cardiology;

8 (D) Gastroenterology;

9 (E) General Surgery;

10 (F) Neurology;

11 (G) OB/GYN;

12 (H) Oncology/Radiation;

13 (I) Ophthalmology;

14 (J) Urology;

15 (K) Behavioral Health;

16 (L) Allergy/Immunology;

17 (M) Chiropractic;

18 (N) Dermatology;

19 (O) Endocrinology;

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

21 (Q) Infectious Disease;

22 (R) Nephrology;

23 (S) Neurosurgery;

24 (T) Orthopedic Surgery;

25 (U) Physiatry/Rehabilitative;

26 (V) Plastic Surgery;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the physicians currently refer beneficiaries, or both; or

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

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

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

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

14 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

1 other information required by Department rule.

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

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

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

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

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

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

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

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

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

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

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

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

26 (A) Primary Care;

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

1 (BB) Outpatient Dialysis; and

2 (CC) HIV.

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

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

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

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

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

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

1 following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 Sec. 5-3. Insurance Code provisions.

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

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

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

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

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

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

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

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

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

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

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

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

26 (B) pro forma financial statements reflecting the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 Sec. 5-3. Insurance Code provisions.

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

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

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

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

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

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

1 1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (305 ILCS 5/5-5.28 new)

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

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

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