

1 AN ACT concerning regulation.

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

4 Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Section 6.11 as follows:

6 (5 ILCS 375/6.11)

7 Sec. 6.11. Required health benefits; Illinois Insurance
8 Code requirements. The program of health benefits shall provide
9 the post-mastectomy care benefits required to be covered by a
10 policy of accident and health insurance under Section 356t of
11 the Illinois Insurance Code. The program of health benefits
12 shall provide the coverage required under Sections 356g,
13 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4,
14 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
15 356z.14, 356z.15, 356z.17, 356z.22, ~~and~~ 356z.25, 356z.26, and
16 356z.29 of the Illinois Insurance Code. The program of health
17 benefits must comply with Sections 155.22a, 155.37, 355b,
18 356z.19, 370c, and 370c.1 of the Illinois Insurance Code.

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

1 whatever reason, is unauthorized.

2 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
3 100-138, eff. 8-18-17; revised 10-3-17.)

4 Section 10. The Counties Code is amended by changing
5 Section 5-1069.3 as follows:

6 (55 ILCS 5/5-1069.3)

7 Sec. 5-1069.3. Required health benefits. If a county,
8 including a home rule county, is a self-insurer for purposes of
9 providing health insurance coverage for its employees, the
10 coverage shall include coverage for the post-mastectomy care
11 benefits required to be covered by a policy of accident and
12 health insurance under Section 356t and the coverage required
13 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
14 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
15 356z.14, 356z.15, 356z.22, ~~and 356z.25,~~ 356z.26, and 356z.29 of
16 the Illinois Insurance Code. The coverage shall comply with
17 Sections 155.22a, 355b, 356z.19, and 370c of the Illinois
18 Insurance Code. The requirement that health benefits be covered
19 as provided in this Section is an exclusive power and function
20 of the State and is a denial and limitation under Article VII,
21 Section 6, subsection (h) of the Illinois Constitution. A home
22 rule county to which this Section applies must comply with
23 every provision of this Section.

24 Rulemaking authority to implement Public Act 95-1045, if

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

6 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
7 100-138, eff. 8-18-17; revised 10-5-17.)

8 Section 15. The Illinois Municipal Code is amended by
9 changing Section 10-4-2.3 as follows:

10 (65 ILCS 5/10-4-2.3)

11 Sec. 10-4-2.3. Required health benefits. If a
12 municipality, including a home rule municipality, is a
13 self-insurer for purposes of providing health insurance
14 coverage for its employees, the coverage shall include coverage
15 for the post-mastectomy care benefits required to be covered by
16 a policy of accident and health insurance under Section 356t
17 and the coverage required under Sections 356g, 356g.5,
18 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10,
19 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~
20 356z.25, 356z.26, and 356z.29 of the Illinois Insurance Code.
21 The coverage shall comply with Sections 155.22a, 355b, 356z.19,
22 and 370c of the Illinois Insurance Code. The requirement that
23 health benefits be covered as provided in this is an exclusive
24 power and function of the State and is a denial and limitation

1 under Article VII, Section 6, subsection (h) of the Illinois
2 Constitution. A home rule municipality to which this Section
3 applies must comply with every provision of this Section.

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

10 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
11 100-138, eff. 8-18-17; revised 10-5-17.)

12 Section 20. The School Code is amended by changing Section
13 10-22.3f as follows:

14 (105 ILCS 5/10-22.3f)

15 Sec. 10-22.3f. Required health benefits. Insurance
16 protection and benefits for employees shall provide the
17 post-mastectomy care benefits required to be covered by a
18 policy of accident and health insurance under Section 356t and
19 the coverage required under Sections 356g, 356g.5, 356g.5-1,
20 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
21 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, 356z.26, and
22 356z.29 of the Illinois Insurance Code. Insurance policies
23 shall comply with Section 356z.19 of the Illinois Insurance
24 Code. The coverage shall comply with Sections 155.22a and 355b

1 of the Illinois Insurance Code.

2 Rulemaking authority to implement Public Act 95-1045, if
3 any, is conditioned on the rules being adopted in accordance
4 with all provisions of the Illinois Administrative Procedure
5 Act and all rules and procedures of the Joint Committee on
6 Administrative Rules; any purported rule not so adopted, for
7 whatever reason, is unauthorized.

8 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
9 revised 9-25-17.)

10 Section 25. The Illinois Insurance Code is amended by
11 changing Section 356z.4 and adding Section 356z.29 as follows:

12 (215 ILCS 5/356z.4)

13 Sec. 356z.4. Coverage for contraceptives.

14 (a) (1) The General Assembly hereby finds and declares all
15 of the following:

16 (A) Illinois has a long history of expanding timely
17 access to birth control to prevent unintended pregnancy.

18 (B) The federal Patient Protection and Affordable Care
19 Act includes a contraceptive coverage guarantee as part of
20 a broader requirement for health insurance to cover key
21 preventive care services without out-of-pocket costs for
22 patients.

23 (C) The General Assembly intends to build on existing
24 State and federal law to promote gender equity and women's

1 health and to ensure greater contraceptive coverage equity
2 and timely access to all federal Food and Drug
3 Administration approved methods of birth control for all
4 individuals covered by an individual or group health
5 insurance policy in Illinois.

6 (D) Medical management techniques such as denials,
7 step therapy, or prior authorization in public and private
8 health care coverage can impede access to the most
9 effective contraceptive methods.

10 (2) As used in this subsection (a):

11 "Contraceptive services" includes consultations,
12 examinations, procedures, and medical services related to the
13 use of contraceptive methods (including natural family
14 planning) to prevent an unintended pregnancy.

15 "Medical necessity", for the purposes of this subsection
16 (a), includes, but is not limited to, considerations such as
17 severity of side effects, differences in permanence and
18 reversibility of contraceptive, and ability to adhere to the
19 appropriate use of the item or service, as determined by the
20 attending provider.

21 "Therapeutic equivalent version" means drugs, devices, or
22 products that can be expected to have the same clinical effect
23 and safety profile when administered to patients under the
24 conditions specified in the labeling and satisfy the following
25 general criteria:

26 (i) they are approved as safe and effective;

1 (ii) they are pharmaceutical equivalents in that they
2 (A) contain identical amounts of the same active drug
3 ingredient in the same dosage form and route of
4 administration and (B) meet compendial or other applicable
5 standards of strength, quality, purity, and identity;

6 (iii) they are bioequivalent in that (A) they do not
7 present a known or potential bioequivalence problem and
8 they meet an acceptable in vitro standard or (B) if they do
9 present such a known or potential problem, they are shown
10 to meet an appropriate bioequivalence standard;

11 (iv) they are adequately labeled; and

12 (v) they are manufactured in compliance with Current
13 Good Manufacturing Practice regulations.

14 (3) An individual or group policy of accident and health
15 insurance amended, delivered, issued, or renewed in this State
16 after the effective date of this amendatory Act of the 99th
17 General Assembly shall provide coverage for all of the
18 following services and contraceptive methods:

19 (A) All contraceptive drugs, devices, and other
20 products approved by the United States Food and Drug
21 Administration. This includes all over-the-counter
22 contraceptive drugs, devices, and products approved by the
23 United States Food and Drug Administration, excluding male
24 condoms. The following apply:

25 (i) If the United States Food and Drug
26 Administration has approved one or more therapeutic

1 equivalent versions of a contraceptive drug, device,
2 or product, a policy is not required to include all
3 such therapeutic equivalent versions in its formulary,
4 so long as at least one is included and covered without
5 cost-sharing and in accordance with this Section.

6 (ii) If an individual's attending provider
7 recommends a particular service or item approved by the
8 United States Food and Drug Administration based on a
9 determination of medical necessity with respect to
10 that individual, the plan or issuer must cover that
11 service or item without cost sharing. The plan or
12 issuer must defer to the determination of the attending
13 provider.

14 (iii) If a drug, device, or product is not covered,
15 plans and issuers must have an easily accessible,
16 transparent, and sufficiently expedient process that
17 is not unduly burdensome on the individual or a
18 provider or other individual acting as a patient's
19 authorized representative to ensure coverage without
20 cost sharing.

21 (iv) This coverage must provide for the dispensing
22 of 12 months' worth of contraception at one time.

23 (B) Voluntary sterilization procedures.

24 (C) Contraceptive services, patient education, and
25 counseling on contraception.

26 (D) Follow-up services related to the drugs, devices,

1 products, and procedures covered under this Section,
2 including, but not limited to, management of side effects,
3 counseling for continued adherence, and device insertion
4 and removal.

5 (4) Except as otherwise provided in this subsection (a), a
6 policy subject to this subsection (a) shall not impose a
7 deductible, coinsurance, copayment, or any other cost-sharing
8 requirement on the coverage provided. The provisions of this
9 paragraph do not apply to coverage of voluntary male
10 sterilization procedures to the extent such coverage would
11 disqualify a high-deductible health plan from eligibility for a
12 health savings account pursuant to the federal Internal Revenue
13 Code, 26 U.S.C. 223.

14 (5) Except as otherwise authorized under this subsection
15 (a), a policy shall not impose any restrictions or delays on
16 the coverage required under this subsection (a).

17 (6) If, at any time, the Secretary of the United States
18 Department of Health and Human Services, or its successor
19 agency, promulgates rules or regulations to be published in the
20 Federal Register or publishes a comment in the Federal Register
21 or issues an opinion, guidance, or other action that would
22 require the State, pursuant to any provision of the Patient
23 Protection and Affordable Care Act (Public Law 111-148),
24 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
25 successor provision, to defray the cost of any coverage
26 outlined in this subsection (a), then this subsection (a) is

1 inoperative with respect to all coverage outlined in this
2 subsection (a) other than that authorized under Section 1902 of
3 the Social Security Act, 42 U.S.C. 1396a, and the State shall
4 not assume any obligation for the cost of the coverage set
5 forth in this subsection (a).

6 (b) This subsection (b) shall become operative if and only
7 if subsection (a) becomes inoperative.

8 An individual or group policy of accident and health
9 insurance amended, delivered, issued, or renewed in this State
10 after the date this subsection (b) becomes operative that
11 provides coverage for outpatient services and outpatient
12 prescription drugs or devices must provide coverage for the
13 insured and any dependent of the insured covered by the policy
14 for all outpatient contraceptive services and all outpatient
15 contraceptive drugs and devices approved by the Food and Drug
16 Administration. Coverage required under this Section may not
17 impose any deductible, coinsurance, waiting period, or other
18 cost-sharing or limitation that is greater than that required
19 for any outpatient service or outpatient prescription drug or
20 device otherwise covered by the policy.

21 Nothing in this subsection (b) shall be construed to
22 require an insurance company to cover services related to
23 permanent sterilization that requires a surgical procedure.

24 As used in this subsection (b), "outpatient contraceptive
25 service" means consultations, examinations, procedures, and
26 medical services, provided on an outpatient basis and related

1 to the use of contraceptive methods (including natural family
2 planning) to prevent an unintended pregnancy.

3 (c) Nothing in this Section shall be construed to require
4 an insurance company to cover services related to an abortion
5 as the term "abortion" is defined in the Illinois Abortion Law
6 of 1975.

7 (d) If a plan or issuer utilizes a network of providers,
8 nothing in this Section shall be construed to require coverage
9 or to prohibit the plan or issuer from imposing cost-sharing
10 for items or services described in this Section that are
11 provided or delivered by an out-of-network provider, unless the
12 plan or issuer does not have in its network a provider who is
13 able to or is willing to provide the applicable items or
14 services.

15 (Source: P.A. 99-672, eff. 1-1-17.)

16 (215 ILCS 5/356z.29 new)

17 Sec. 356z.29. Coverage for fertility preservation
18 treatments.

19 (a) As used in this Section:

20 "Iatrogenic infertility" means in impairment of
21 fertility by surgery, radiation, chemotherapy, or other
22 medical treatment affecting reproductive organs or
23 processes.

24 "May directly or indirectly cause" means the likely
25 possibility that treatment will cause a side effect of

1 infertility, based upon current evidence-based standards
2 of care established by the American Society for
3 Reproductive Medicine, the American Society of Clinical
4 Oncology, or other national medical associations that
5 follow current evidence-based standards of care.

6 "Standard fertility preservation services" means
7 procedures based upon current evidence-based standards of
8 care established by the American Society for Reproductive
9 Medicine, the American Society of Clinical Oncology, or
10 other national medical associations that follow current
11 evidence-based standards of care.

12 (b) An individual or group policy of accident and health
13 insurance amended, delivered, issued, or renewed in this State
14 after the effective date of this amendatory Act of the 100th
15 General Assembly must provide coverage for medically necessary
16 expenses for standard fertility preservation services when a
17 necessary medical treatment may directly or indirectly cause
18 iatrogenic infertility to an enrollee.

19 (c) In determining coverage pursuant to this Section, an
20 insurer shall not discriminate based on an individuals expected
21 length of life, present or predicted disability, degree of
22 medical dependency, quality of life, or other health
23 conditions, nor based on personal characteristics, including
24 age, sex, sexual orientation, or marital status.

25 Section 30. The Health Maintenance Organization Act is

1 amended by changing Section 5-3 as follows:

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

3 Sec. 5-3. Insurance Code provisions.

4 (a) Health Maintenance Organizations shall be subject to
5 the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
6 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,
7 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3,
8 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4,
9 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12,
10 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21,
11 356z.22, 356z.25, 356z.26, 356z.29, 364, 364.01, 367.2,
12 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401,
13 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
14 paragraph (c) of subsection (2) of Section 367, and Articles
15 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of
16 the Illinois Insurance Code.

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

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

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

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

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 financial
11 conditions of the acquired Health Maintenance Organization
12 after the merger, consolidation, or other acquisition of
13 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 to
18 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, take
23 into account the effect of the management contract or service
24 agreement on the continuation of benefits to enrollees and the
25 financial condition of the health maintenance organization to
26 be managed or serviced, and (ii) need not take into account the

1 effect of the management contract or service agreement on
2 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 Health
7 Maintenance Organization may by contract agree with a group or
8 other enrollment unit to effect refunds or charge additional
9 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 not
15 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 the
15 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 accordance
23 with all provisions of the Illinois Administrative Procedure
24 Act and all rules and procedures of the Joint Committee on
25 Administrative Rules; any purported rule not so adopted, for
26 whatever reason, is unauthorized.

1 (Source: P.A. 99-761, eff. 1-1-18; 100-24, eff. 7-18-17;
2 100-138, eff. 8-18-17; revised 10-5-17.)

3 Section 35. The Limited Health Service Organization Act is
4 amended by changing Section 4003 as follows:

5 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

6 Sec. 4003. Illinois Insurance Code provisions. Limited
7 health service organizations shall be subject to the provisions
8 of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3,
9 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6,
10 154.7, 154.8, 155.04, 155.37, 355.2, 355.3, 355b, 356v,
11 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 368a,
12 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and
13 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2,
14 XXV, and XXVI of the Illinois Insurance Code. For purposes of
15 the Illinois Insurance Code, except for Sections 444 and 444.1
16 and Articles XIII and XIII 1/2, limited health service
17 organizations in the following categories are deemed to be
18 domestic companies:

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

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

1 1/2 of the Illinois Insurance Code.
2 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
3 100-201, eff. 8-18-17; revised 10-5-17.)

4 Section 40. The Voluntary Health Services Plans Act is
5 amended by changing Section 10 as follows:

6 (215 ILCS 165/10) (from Ch. 32, par. 604)

7 Sec. 10. Application of Insurance Code provisions. Health
8 services plan corporations and all persons interested therein
9 or dealing therewith shall be subject to the provisions of
10 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
11 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g,
12 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y,
13 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
14 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18,
15 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 364.01,
16 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
17 and paragraphs (7) and (15) of Section 367 of the Illinois
18 Insurance Code.

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

1 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
2 revised 10-5-17.)

3 Section 45. The Illinois Public Aid Code is amended by
4 changing Section 5-16.8 as follows:

5 (305 ILCS 5/5-16.8)

6 Sec. 5-16.8. Required health benefits. The medical
7 assistance program shall (i) provide the post-mastectomy care
8 benefits required to be covered by a policy of accident and
9 health insurance under Section 356t and the coverage required
10 under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.26, and
11 356z.29 ~~and 356z.25~~ of the Illinois Insurance Code and (ii) be
12 subject to the provisions of Sections 356z.19, 364.01, 370c,
13 and 370c.1 of the Illinois Insurance Code.

14 On and after July 1, 2012, the Department shall reduce any
15 rate of reimbursement for services or other payments or alter
16 any methodologies authorized by this Code to reduce any rate of
17 reimbursement for services or other payments in accordance with
18 Section 5-5e.

19 To ensure full access to the benefits set forth in this
20 Section, on and after January 1, 2016, the Department shall
21 ensure that provider and hospital reimbursement for
22 post-mastectomy care benefits required under this Section are
23 no lower than the Medicare reimbursement rate.

24 (Source: P.A. 99-433, eff. 8-21-15; 99-480, eff. 9-9-15;

1 99-642, eff. 7-28-16; 100-138, eff. 8-18-17; revised 1-29-18.)