1 AN ACT in relation to insurance.

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

4 Section 5. The Comprehensive Health Insurance Plan Act
5 is amended by changing Sections 2, 3, and 15 as follows:

6 (215 ILCS 105/2) (from Ch. 73, par. 1302)
7 Sec. 2. Definitions. As used in this Act, unless the
8 context otherwise requires:
9 "Plan administrator" means the insurer or third party
10 administrator designated under Section 5 of this Act.
11 "Benefits plan" means the coverage to be offered by the
12 Plan to eligible persons and federally eligible individuals
13 pursuant to this Act.
14 "Board" means the Illinois Comprehensive Health Insurance
15 Board.
16 "Church plan" has the same meaning given that term in the
17 federal Health Insurance Portability and Accountability Act
18 of 1996.
19 "Continuation coverage" means continuation of coverage
20 under a group health plan or other health insurance coverage
21 for former employees or dependents of former employees that
22 would otherwise have terminated under the terms of that
23 coverage pursuant to any continuation provisions under
24 federal or State law, including the Consolidated Omnibus
25 Budget Reconciliation Act of 1985 (COBRA), as amended,
26 Sections 367.2, 367e, and 367e.1 of the Illinois Insurance
27 Code, or any other similar requirement in another State.
28 "Covered person" means a person who is and continues to
29 remain eligible for Plan coverage and is covered under one of
30 the benefit plans offered by the Plan.
31 "Creditable coverage" means, with respect to a federally

1 eligible individual, coverage of the individual under any of
2 the following:
3 (A) A group health plan.
4 (B) Health insurance coverage (including group
5 health insurance coverage).
6 (C) Medicare.
7 (D) Medical assistance.
8 (E) Chapter 55 of title 10, United States Code.
9 (F) A medical care program of the Indian Health
10 Service or of a tribal organization.
11 (G) A state health benefits risk pool.
12 (H) A health plan offered under Chapter 89 of title
13 5, United States Code.
14 (I) A public health plan (as defined in regulations
15 consistent with Section 104 of the Health Care
16 Portability and Accountability Act of 1996 that may be
17 promulgated by the Secretary of the U.S. Department of
18 Health and Human Services).
19 (J) A health benefit plan under Section 5(e) of the
20 Peace Corps Act (22 U.S.C. 2504(e)).
21 (K) Any other qualifying coverage required by the
22 federal Health Insurance Portability and Accountability
23 Act of 1996, as it may be amended, or regulations under
24 that Act.
25 "Creditable coverage" does not include coverage
26 consisting solely of coverage of excepted benefits, as
27 defined in Section 2791(c) of title XXVII of the Public
28 Health Service Act (42 U.S.C. 300 gg-91), nor does it include
29 any period of coverage under any of items (A) through (K)
30 that occurred before a break of more than 90 days or, if
31 ~~after-September-30,-2003,~~ the individual has ~~either~~ been
32 certified as eligible pursuant to the federal Trade Act of
33 2002 ~~or-initially-been-paid-a-benefit-by-the-Pension--Benefit~~
34 ~~Guaranty-Corporation~~, a break of more than 63 days during all

of which the individual was not covered under any of items (A) through (K) above.

~~For-an--individual--who--between--December--1,--2002--and September--30,-2003-has-either-(1)-been-certified-as-eligible pursuant-to-the-federal-Trade-Act-of-2002,-(2)-initially-been paid-a-benefit-by-the-Pension-Benefit--Guaranty--Corporation, or--(3)--as-of-December-1,-2002,-been-receiving-benefits-from the--Pension--Benefit--Guaranty--Corporation--and---who---has qualified--health--insurance,-as-defined-by-the-federal-Trade Act-of-2002,-"creditable-coverage"--includes--any--period--of coverage--aggregating-3-or-more-months-under-any-of-items-(A) through-(K),-irrespective-of-the-length-of-a-break-during-all of-which-the-individual-was-not-covered-under--any--of--items (A)-through-(K).~~

Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

"Direct Illinois premiums" means, for Illinois business, an insurer's direct premium income for the kinds of business

1 described in clause (b) of Class 1 or clause (a) of Class 2
2 of Section 4 of the Illinois Insurance Code, and direct
3 premium income of a health maintenance organization or a
4 voluntary health services plan, except it shall not include
5 credit health insurance as defined in Article IX 1/2 of the
6 Illinois Insurance Code.
7 "Director" means the Director of the Illinois Department
8 of Insurance.
9 "Eligible person" means a resident of this State who
10 qualifies for Plan coverage under Section 7 of this Act.
11 "Employee" means a resident of this State who is employed
12 by an employer or has entered into the employment of or works
13 under contract or service of an employer including the
14 officers, managers and employees of subsidiary or affiliated
15 corporations and the individual proprietors, partners and
16 employees of affiliated individuals and firms when the
17 business of the subsidiary or affiliated corporations, firms
18 or individuals is controlled by a common employer through
19 stock ownership, contract, or otherwise.
20 "Employer" means any individual, partnership,
21 association, corporation, business trust, or any person or
22 group of persons acting directly or indirectly in the
23 interest of an employer in relation to an employee, for which
24 one or more persons is gainfully employed.
25 "Family" coverage means the coverage provided by the Plan
26 for the covered person and his or her eligible dependents who
27 also are covered persons.
28 "Federally eligible individual" means an individual
29 resident of this State:
30 (1)(A) for whom, as of the date on which the
31 individual seeks Plan coverage under Section 15 of this
32 Act, the aggregate of the periods of creditable coverage
33 is 18 or more months or, if the individual has ~~either (i)~~
34 been certified as eligible pursuant to the federal Trade

Act of 2002, ~~(ii)-initially-been-paid-a--benefit--by--the Pension--Benefit--Guaranty--Corporation,--or--(iii)-as-of December--1,--2002,--been--receiving--benefits--from--the Pension-Benefit-Guaranty-Corporation--and--has--qualified health--insurance,-as-defined-by-the-federal-Trade-Act-of 2002,~~ 3 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), (B) part A or part B of Medicare due to age (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), or (C) medical assistance, and does not have other health insurance coverage (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002);

(3) with respect to whom (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual (other than an individual who has ~~either-(A)~~ been certified as eligible pursuant to the federal Trade Act of 2002~~,--(B)-initially-been-paid-a benefit-by-the-Pension-Benefit-Guaranty--Corporation,--or~~

~~(C)--as-of-December-1,-2002,-been-receiving-benefits-from the-Pension-Benefit--Guaranty--Corporation--and--who--has qualified--health--insurance,--as--defined-by-the-federal Trade-Act--of--2002~~) had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

However, an individual who has ~~either~~ been certified as eligible pursuant to the federal Trade Act of 2002 ~~or initially-been-paid-a-benefit-by-the-Pension-Benefit-Guaranty Corporation~~ shall not be required to elect continuation coverage under a COBRA continuation provision or under a similar state program.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan.

"Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by

insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

"Health Maintenance Organization" means an organization as defined in the Health Maintenance Organization Act.

"Hospice" means a program as defined in and licensed under the Hospice Program Licensing Act.

"Hospital" means a duly licensed institution as defined in the Hospital Licensing Act, an institution that meets all comparable conditions and requirements in effect in the state in which it is located, or the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance.

"Insured" means any individual resident of this State who is eligible to receive benefits from any insurer (including health insurance coverage offered in connection with a group health plan) or health insurance issuer as defined in this

1 Section.
2 "Insurer" means any insurance company authorized to
3 transact health insurance business in this State and any
4 corporation that provides medical services and is organized
5 under the Voluntary Health Services Plans Act or the Health
6 Maintenance Organization Act.
7 "Medical assistance" means the State medical assistance
8 or medical assistance no grant (MANG) programs provided under
9 Title XIX of the Social Security Act and Articles V (Medical
10 Assistance) and VI (General Assistance) of the Illinois
11 Public Aid Code (or any successor program) or under any
12 similar program of health care benefits in a state other than
13 Illinois.
14 "Medically necessary" means that a service, drug, or
15 supply is necessary and appropriate for the diagnosis or
16 treatment of an illness or injury in accord with generally
17 accepted standards of medical practice at the time the
18 service, drug, or supply is provided. When specifically
19 applied to a confinement it further means that the diagnosis
20 or treatment of the covered person's medical symptoms or
21 condition cannot be safely provided to that person as an
22 outpatient. A service, drug, or supply shall not be medically
23 necessary if it: (i) is investigational, experimental, or for
24 research purposes; or (ii) is provided solely for the
25 convenience of the patient, the patient's family, physician,
26 hospital, or any other provider; or (iii) exceeds in scope,
27 duration, or intensity that level of care that is needed to
28 provide safe, adequate, and appropriate diagnosis or
29 treatment; or (iv) could have been omitted without adversely
30 affecting the covered person's condition or the quality of
31 medical care; or (v) involves the use of a medical device,
32 drug, or substance not formally approved by the United States
33 Food and Drug Administration.
34 "Medical care" means the ordinary and usual professional

1 services rendered by a physician or other specified provider
2 during a professional visit for treatment of an illness or
3 injury.
4 "Medicare" means coverage under both Part A and Part B of
5 Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395,
6 et seq.
7 "Minimum premium plan" means an arrangement whereby a
8 specified amount of health care claims is self-funded, but
9 the insurance company assumes the risk that claims will
10 exceed that amount.
11 "Participating transplant center" means a hospital
12 designated by the Board as a preferred or exclusive provider
13 of services for one or more specified human organ or tissue
14 transplants for which the hospital has signed an agreement
15 with the Board to accept a transplant payment allowance for
16 all expenses related to the transplant during a transplant
17 benefit period.
18 "Physician" means a person licensed to practice medicine
19 pursuant to the Medical Practice Act of 1987.
20 "Plan" means the Comprehensive Health Insurance Plan
21 established by this Act.
22 "Plan of operation" means the plan of operation of the
23 Plan, including articles, bylaws and operating rules, adopted
24 by the board pursuant to this Act.
25 "Provider" means any hospital, skilled nursing facility,
26 hospice, home health agency, physician, registered pharmacist
27 acting within the scope of that registration, or any other
28 person or entity licensed in Illinois to furnish medical
29 care.
30 "Qualified high risk pool" has the same meaning given
31 that term in the federal Health Insurance Portability and
32 Accountability Act of 1996.
33 "Resident" means a person who is and continues to be
34 legally domiciled and physically residing on a permanent and

1 full-time basis in a place of permanent habitation in this
2 State that remains that person's principal residence and from
3 which that person is absent only for temporary or transitory
4 purpose.
5 "Skilled nursing facility" means a facility or that
6 portion of a facility that is licensed by the Illinois
7 Department of Public Health under the Nursing Home Care Act
8 or a comparable licensing authority in another state to
9 provide skilled nursing care.
10 "Stop-loss coverage" means an arrangement whereby an
11 insurer insures against the risk that any one claim will
12 exceed a specific dollar amount or that the entire loss of a
13 self-insurance plan will exceed a specific amount.
14 "Third party administrator" means an administrator as
15 defined in Section 511.101 of the Illinois Insurance Code who
16 is licensed under Article XXXI 1/4 of that Code.
17 (Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03;
18 93-34, eff. 6-23-03; 93-477, eff. 8-8-03; revised 8-21-03.)

19 (215 ILCS 105/3) (from Ch. 73, par. 1303)
20 Sec. 3. Operation of the Plan.
21 a. There is hereby created an Illinois Comprehensive
22 Health Insurance Plan.
23 b. The Plan shall operate subject to the supervision and
24 control of the board. The board is created as a political
25 subdivision and body politic and corporate and, as such, is
26 not a State agency. The board shall consist of 10 public
27 members, appointed by the Governor with the advice and
28 consent of the Senate.
29 Initial members shall be appointed to the Board by the
30 Governor as follows: 2 members to serve until July 1, 1988,
31 and until their successors are appointed and qualified; 2
32 members to serve until July 1, 1989, and until their
33 successors are appointed and qualified; 3 members to serve

1 until July 1, 1990, and until their successors are appointed
2 and qualified; and 3 members to serve until July 1, 1991, and
3 until their successors are appointed and qualified. As terms
4 of initial members expire, their successors shall be
5 appointed for terms to expire the first day in July 3 years
6 thereafter, and until their successors are appointed and
7 qualified.

8 Any vacancy in the Board occurring for any reason other
9 than the expiration of a term shall be filled for the
10 unexpired term in the same manner as the original
11 appointment.

12 Any member of the Board may be removed by the Governor
13 for neglect of duty, misfeasance, malfeasance, or nonfeasance
14 in office.

15 In addition, a representative of the <u>Governor's Office of</u>
16 <u>Management and Budget</u> ~~Bureau-of-the-Budget~~, a representative
17 of the Office of the Attorney General and the Director or the
18 Director's designated representative shall be members of the
19 board. Four members of the General Assembly, one each
20 appointed by the President and Minority Leader of the Senate
21 and by the Speaker and Minority Leader of the House of
22 Representatives, shall serve as nonvoting members of the
23 board. At least 2 of the public members shall be individuals
24 reasonably expected to qualify for coverage under the Plan,
25 the parent or spouse of such an individual, or a surviving
26 family member of an individual who could have qualified for
27 the plan during his lifetime. The Director or Director's
28 representative shall be the chairperson of the board.
29 Members of the board shall receive no compensation, but shall
30 be reimbursed for reasonable expenses incurred in the
31 necessary performance of their duties.

32 c. The board shall make an annual report in September
33 and shall file the report with the Secretary of the Senate
34 and the Clerk of the House of Representatives. The report

1 shall summarize the activities of the Plan in the preceding
2 calendar year, including net written and earned premiums, the
3 expense of administration, the paid and incurred losses for
4 the year and other information as may be requested by the
5 General Assembly. The report shall also include analysis and
6 recommendations regarding utilization review, quality
7 assurance and access to cost effective quality health care.
8 d. In its plan of operation the board shall:
9 (1) Establish procedures for selecting a plan
10 administrator in accordance with Section 5 of this Act.
11 (2) Establish procedures for the operation of the
12 board.
13 (3) Create a Plan fund, under management of the
14 board, to fund administrative, claim, and other expenses
15 of the Plan.
16 (4) Establish procedures for the handling and
17 accounting of assets and monies of the Plan.
18 (5) Develop and implement a program to publicize
19 the existence of the Plan, the eligibility requirements
20 and procedures for enrollment and to maintain public
21 awareness of the Plan.
22 (6) Establish procedures under which applicants and
23 participants may have grievances reviewed by a grievance
24 committee appointed by the board. The grievances shall
25 be reported to the board immediately after completion of
26 the review. The Department and the board shall retain
27 all written complaints regarding the Plan for at least 3
28 years. Oral complaints shall be reduced to written form
29 and maintained for at least 3 years.
30 (7) Provide for other matters as may be necessary
31 and proper for the execution of its powers, duties and
32 obligations under the Plan.
33 e. No later than 5 years after the Plan is operative the
34 board and the Department shall conduct cooperatively a study

1 of the Plan and the persons insured by the Plan to determine:
2 (1) claims experience including a breakdown of medical
3 conditions for which claims were paid; (2) whether
4 availability of the Plan affected employment opportunities
5 for participants; (3) whether availability of the Plan
6 affected the receipt of medical assistance benefits by Plan
7 participants; (4) whether a change occurred in the number of
8 personal bankruptcies due to medical or other health related
9 costs; (5) data regarding all complaints received about the
10 Plan including its operation and services; (6) and any other
11 significant observations regarding utilization of the Plan.
12 The study shall culminate in a written report to be presented
13 to the Governor, the President of the Senate, the Speaker of
14 the House and the chairpersons of the House and Senate
15 Insurance Committees. The report shall be filed with the
16 Secretary of the Senate and the Clerk of the House of
17 Representatives. The report shall also be available to
18 members of the general public upon request.
19 f. The board may:
20 (1) Prepare and distribute certificate of
21 eligibility forms and enrollment instruction forms to
22 insurance producers and to the general public in this
23 State.
24 (2) Provide for reinsurance of risks incurred by
25 the Plan and enter into reinsurance agreements with
26 insurers to establish a reinsurance plan for risks of
27 coverage described in the Plan, or obtain commercial
28 reinsurance to reduce the risk of loss through the Plan.
29 (3) Issue additional types of health insurance
30 policies to provide optional coverages as are otherwise
31 permitted by this Act including a Medicare supplement
32 policy designed to supplement Medicare.
33 (4) Provide for and employ cost containment
34 measures and requirements including, but not limited to,

1 preadmission certification, second surgical opinion,
2 concurrent utilization review programs, and individual
3 case management for the purpose of making the pool more
4 cost effective.
5 (5) Design, utilize, contract, or otherwise arrange
6 for the delivery of cost effective health care services,
7 including establishing or contracting with preferred
8 provider organizations, health maintenance organizations,
9 and other limited network provider arrangements.
10 (6) Adopt bylaws, rules, regulations, policies and
11 procedures as may be necessary or convenient for the
12 implementation of the Act and the operation of the Plan.
13 (7) Administer separate pools, separate accounts,
14 or other plans or arrangements as required by this Act to
15 separate federally eligible individuals or groups of
16 federally eligible individuals who qualify for plan
17 coverage under Section 15 of this Act from eligible
18 persons or groups of eligible persons who qualify for
19 plan coverage under Section 7 of this Act and apportion
20 the costs of the administration among such separate
21 pools, separate accounts, or other plans or arrangements.
22 g. The Director may, by rule, establish additional
23 powers and duties of the board and may adopt rules for any
24 other purposes, including the operation of the Plan, as are
25 necessary or proper to implement this Act.
26 h. The board is not liable for any obligation of the
27 Plan. There is no liability on the part of any member or
28 employee of the board or the Department, and no cause of
29 action of any nature may arise against them, for any action
30 taken or omission made by them in the performance of their
31 powers and duties under this Act, unless the action or
32 omission constitutes willful or wanton misconduct. The board
33 may provide in its bylaws or rules for indemnification of,
34 and legal representation for, its members and employees.

1 i. There is no liability on the part of any insurance
2 producer for the failure of any applicant to be accepted by
3 the Plan unless the failure of the applicant to be accepted
4 by the Plan is due to an act or omission by the insurance
5 producer which constitutes willful or wanton misconduct.
6 (Source: P.A. 92-597, eff. 6-28-02; revised 8-23-03.)

7 (215 ILCS 105/15)
8 Sec. 15. Alternative portable coverage for federally
9 eligible individuals.
10 (a) Notwithstanding the requirements of subsection a. of
11 Section 7 and except as otherwise provided in this Section,
12 any federally eligible individual for whom a Plan
13 application, and such enclosures and supporting documentation
14 as the Board may require, is received by the Board within 90
15 days after the termination of prior creditable coverage shall
16 qualify to enroll in the Plan under the portability
17 provisions of this Section.
18 ~~A-federally-eligible-person-who-between-December-1,--2002~~
19 ~~and--September--30,--2003--has--either--(1)-been-certified-as~~
20 ~~eligible-pursuant-to-the--federal--Trade--Act--of--2002,--(2)~~
21 ~~initially-been-paid-a-benefit-by-the-Pension-Benefit-Guaranty~~
22 ~~Corporation,--or--(3)--as-of-December-1,-2002,-been-receiving~~
23 ~~benefits-from-the-Pension-Benefit-Guaranty--Corporation,--who~~
24 ~~has--qualified--health--insurance,--as-defined-by-the-federal~~
25 ~~Trade-Act-of-2002,-and-whose-Plan-application-and--enclosures~~
26 ~~and--supporting--documentation,--as-the-Board-may-require,-is~~
27 ~~received-by-the--Board--after--the--termination--of--previous~~
28 ~~creditable-coverage-shall-qualify-to-enroll-in-the-Plan-under~~
29 ~~the-portability-provisions-of-this-Section.~~
30 A federally eligible person who~~,--after-September-30,~~
31 ~~2003,~~ has ~~either~~ been certified as eligible pursuant to the
32 federal Trade Act of 2002 ~~or-initially-been-paid-a-benefit-by~~
33 ~~the--Pension--Benefit--Guaranty--Corporation~~ and whose Plan

application and enclosures and supporting documentation as the Board may require is received by the Board within 63 days after the termination of previous creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.

(b) Any federally eligible individual seeking Plan coverage under this Section must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the Board's satisfaction, that he or she meets all of the requirements to be a federally eligible individual and is currently and permanently residing in this State (as of the date his or her application was received by the Board).

(c) Except as otherwise provided in this Section, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 90 day period during all of which the individual was not covered under any creditable coverage.

~~For--a--federally-eligible-person-who-between-December-1, 2002-and-September-30,-2003-has-either-(1)-been-certified--as eligible--pursuant--to--the--federal--Trade--Act-of-2002,-(2) initially-been-paid-a-benefit-by-the-Pension-Benefit-Guaranty Corporation,-or-(3)-as-of-December-1,--2002,--been--receiving benefits--from--the--Pension-Benefit-Guaranty-Corporation-and who-has-qualified-health-insurance,-as-defined-by-the-federal Trade-Act-of-2002,-a-period-of-creditable-coverage--shall--be counted,--with--respect--to--qualifying-an-applicant-for-Plan coverage--as--a--federally--eligible--individual--under--this Section,-when-the-application-for-Plan-coverage-was--received by-the-Board.~~

For a federally eligible person who~~, after September 30, 2003,~~ has ~~either~~ been certified as eligible pursuant to the federal Trade Act of 2002 ~~or initially been paid a benefit by the Pension Benefit Guaranty Corporation~~, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 63 day period during all of which the individual was not covered under any creditable coverage.

(d) Any federally eligible individual who the Board determines qualifies for Plan coverage under this Section shall be offered his or her choice of enrolling in one of alternative portability health benefit plans which the Board is authorized under this Section to establish for these federally eligible individuals and their dependents.

(e) The Board shall offer a choice of health care coverages consistent with major medical coverage under the alternative health benefit plans authorized by this Section to every federally eligible individual. The coverages to be offered under the plans, the schedule of benefits, deductibles, co-payments, exclusions, and other limitations shall be approved by the Board. One optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this State or a standard option of coverage available under the group or individual health insurance laws of the State. The standard benefit plan that is authorized by Section 8 of this Act may be used for this purpose. The Board may also offer a preferred provider option and such other options as the Board determines may be appropriate for these federally eligible individuals who qualify for Plan coverage pursuant to this Section.

1 (f) Notwithstanding the requirements of subsection f. of
2 Section 8, any plan coverage that is issued to federally
3 eligible individuals who qualify for the Plan pursuant to the
4 portability provisions of this Section shall not be subject
5 to any preexisting conditions exclusion, waiting period, or
6 other similar limitation on coverage.
7 (g) Federally eligible individuals who qualify and
8 enroll in the Plan pursuant to this Section shall be required
9 to pay such premium rates as the Board shall establish and
10 approve in accordance with the requirements of Section 7.1 of
11 this Act.
12 (h) A federally eligible individual who qualifies and
13 enrolls in the Plan pursuant to this Section must satisfy on
14 an ongoing basis all of the other eligibility requirements of
15 this Act to the extent not inconsistent with the federal
16 Health Insurance Portability and Accountability Act of 1996
17 in order to maintain continued eligibility for coverage under
18 the Plan.
19 (Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03;
20 93-34, eff. 6-23-03.)

21 Section 99. Effective date. This Act takes effect upon
22 becoming law.