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 Comprehensive Health Insurance Plan Act is
5 amended by changing Sections 7 and 8 as follows:

6 (215 ILCS 105/7) (from Ch. 73, par. 1307)
7 Sec. 7. Eligibility.
8 a. Except as provided in subsection (e) of this Section or
9 in Section 15 of this Act, any person who is either a citizen
10 of the United States or an alien lawfully admitted for
11 permanent residence and who has been for a period of at least
12 180 days and continues to be a resident of this State shall be
13 eligible for Plan coverage under this Section if evidence is
14 provided of:
15 (1) A notice of rejection or refusal to issue
16 substantially similar individual health insurance coverage
17 for health reasons by a health insurance issuer; or
18 (2) A refusal by a health insurance issuer to issue
19 individual health insurance coverage except at a rate
20 exceeding the applicable Plan rate for which the person is
21 responsible.
22 A rejection or refusal by a group health plan or health
23 insurance issuer offering only stop-loss or excess of loss

insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection.

b. The board shall promulgate a list of medical or health conditions for which a person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and a resident of this State would be eligible for Plan coverage without applying for health insurance coverage pursuant to subsection a. of this Section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection a. of this Section. The list shall be effective on the first day of the operation of the Plan and may be amended from time to time as appropriate.

c. Family members of the same household who each are covered persons are eligible for optional family coverage under the Plan.

d. For persons qualifying for coverage in accordance with Section 7 of this Act, the board shall, if it determines that such appropriations as are made pursuant to Section 12 of this Act are insufficient to allow the board to accept all of the eligible persons which it projects will apply for enrollment under the Plan, limit or close enrollment to ensure that the Plan is not over-subscribed and that it has sufficient resources to meet its obligations to existing enrollees. The

board shall not limit or close enrollment for federally eligible individuals.

e. A person shall not be eligible for coverage under the Plan if:

(1) He or she has or obtains other coverage under a group health plan or health insurance coverage substantially similar to or better than a Plan policy as an insured or covered dependent or would be eligible to have that coverage if he or she elected to obtain it. Persons otherwise eligible for Plan coverage may, however, solely for the purpose of having coverage for a pre-existing condition, maintain other coverage only while satisfying any pre-existing condition waiting period under a Plan policy or a subsequent replacement policy of a Plan policy.

(1.1) His or her prior coverage under a group health plan or health insurance coverage, provided or arranged by an employer of more than 10 employees was discontinued for any reason without the entire group or plan being discontinued and not replaced, provided he or she remains an employee, or dependent thereof, of the same employer.

(2) He or she is a recipient of or is approved to receive medical assistance, except that a person may continue to receive medical assistance through the medical assistance no grant program, but only while satisfying the requirements for a preexisting condition under Section 8, subsection f. of this Act. Payment of premiums pursuant to

this Act shall be allocable to the person's spenddown for purposes of the medical assistance no grant program, but that person shall not be eligible for any Plan benefits while that person remains eligible for medical assistance. If the person continues to receive or be approved to receive medical assistance through the medical assistance no grant program at or after the time that requirements for a preexisting condition are satisfied, the person shall not be eligible for coverage under the Plan. In that circumstance, coverage under the plan shall terminate as of the expiration of the preexisting condition limitation period. Under all other circumstances, coverage under the Plan shall automatically terminate as of the effective date of any medical assistance.

(3) Except as provided in Section 15, the person has previously participated in the Plan and voluntarily terminated Plan coverage, unless 12 months have elapsed since the person's latest voluntary termination of coverage.

(4) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the Plan shall be limited to benefits incurred under the Plan for the time period for which premiums had been paid and the covered person remained eligible for Plan coverage.

(5) The Plan ~~(i) until 3 years after the effective date~~

~~of this amendatory Act of the 95th General Assembly~~ has paid a total of $5,000,000 ~~$2,000,000~~ in benefits on behalf of the covered person ~~or (ii) 3 years or more after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $1,500,000 in benefits on behalf of the covered person~~.

(6) The person is a resident of a public institution.

(7) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care provider or, except when a person's premium is paid by the U.S. Treasury Department pursuant to the federal Trade Act of 2002.

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or

1 assets remaining from those sources in an amount in excess
2 of $300,000.
3 (9) Within the 5 years prior to the date a person's
4 Plan application is received by the Board, the person's
5 coverage under any health care benefit program as defined
6 in 18 U.S.C. 24, including any public or private plan or
7 contract under which any medical benefit, item, or service
8 is provided, was terminated as a result of any act or
9 practice that constitutes fraud under State or federal law
10 or as a result of an intentional misrepresentation of
11 material fact; or if that person knowingly and willfully
12 obtained or attempted to obtain, or fraudulently aided or
13 attempted to aid any other person in obtaining, any
14 coverage or benefits under the Plan to which that person
15 was not entitled.
16 f. The board or the administrator shall require
17 verification of residency and may require any additional
18 information or documentation, or statements under oath, when
19 necessary to determine residency upon initial application and
20 for the entire term of the policy.
21 g. Coverage shall cease (i) on the date a person is no
22 longer a resident of Illinois, (ii) on the date a person
23 requests coverage to end, (iii) upon the death of the covered
24 person, (iv) on the date State law requires cancellation of the
25 policy, or (v) at the Plan's option, 30 days after the Plan
26 makes any inquiry concerning a person's eligibility or place of

residence to which the person does not reply.

h. Except under the conditions set forth in subsection g of this Section, the coverage of any person who ceases to meet the eligibility requirements of this Section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

(Source: P.A. 94-17, eff. 1-1-06; 94-737, eff. 5-3-06; 95-547, eff. 8-29-07.)

(215 ILCS 105/8) (from Ch. 73, par. 1308)

Sec. 8. Minimum benefits.

a. Availability. The Plan shall offer in a periodically renewable policy major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Plan shall pay an eligible person's covered expenses, subject to limit on the deductible and coinsurance payments authorized under paragraph (4) of subsection d of this Section, up to a lifetime benefit limit of <u>$5,000,000</u> ~~$2,000,000 until 3 years after the effective date of this amendatory Act of the 95th General Assembly, and $1,500,000 in benefits 3 years or more after the effective date of this amendatory Act of the 95th General Assembly per covered individual~~. The maximum limit under this subsection shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board. Any person who otherwise would qualify for coverage under the Plan, but is excluded because he

1 or she is eligible for Medicare, shall be eligible for any
2 separate Medicare supplement policy or policies which the Board
3 may offer.

4 b. Outline of benefits. Covered expenses shall be limited
5 to the usual and customary charge, including negotiated fees,
6 in the locality for the following services and articles when
7 prescribed by a physician and determined by the Plan to be
8 medically necessary for the following areas of services,
9 subject to such separate deductibles, co-payments, exclusions,
10 and other limitations on benefits as the Board shall establish
11 and approve, and the other provisions of this Section:

12 (1) Hospital services, except that any services
13 provided by a hospital that is located more than 75 miles
14 outside the State of Illinois shall be covered only for a
15 maximum of 45 days in any calendar year. With respect to
16 covered expenses incurred during any calendar year ending
17 on or after December 31, 1999, inpatient hospitalization of
18 an eligible person for the treatment of mental illness at a
19 hospital located within the State of Illinois shall be
20 subject to the same terms and conditions as for any other
21 illness.

22 (2) Professional services for the diagnosis or
23 treatment of injuries, illnesses or conditions, other than
24 dental and mental and nervous disorders as described in
25 paragraph (17), which are rendered by a physician, or by
26 other licensed professionals at the physician's direction.

1 This includes reconstruction of the breast on which a
2 mastectomy was performed; surgery and reconstruction of
3 the other breast to produce a symmetrical appearance; and
4 prostheses and treatment of physical complications at all
5 stages of the mastectomy, including lymphedemas.
6 (2.5) Professional services provided by a physician to
7 children under the age of 16 years for physical
8 examinations and age appropriate immunizations ordered by
9 a physician licensed to practice medicine in all its
10 branches.
11 (3) (Blank).
12 (4) Outpatient prescription drugs that by law require a
13 prescription written by a physician licensed to practice
14 medicine in all its branches subject to such separate
15 deductible, copayment, and other limitations or
16 restrictions as the Board shall approve, including the use
17 of a prescription drug card or any other program, or both.
18 (5) Skilled nursing services of a licensed skilled
19 nursing facility for not more than 120 days during a policy
20 year.
21 (6) Services of a home health agency in accord with a
22 home health care plan, up to a maximum of 270 visits per
23 year.
24 (7) Services of a licensed hospice for not more than
25 180 days during a policy year.
26 (8) Use of radium or other radioactive materials.

(9) Oxygen.

(10) Anesthetics.

(11) Orthoses and prostheses other than dental.

(12) Rental or purchase in accordance with Board policies or procedures of durable medical equipment, other than eyeglasses or hearing aids, for which there is no personal use in the absence of the condition for which it is prescribed.

(13) Diagnostic x-rays and laboratory tests.

(14) Oral surgery (i) for excision of partially or completely unerupted impacted teeth when not performed in connection with the routine extraction or repair of teeth; (ii) for excision of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth; (iii) required for correction of cleft lip and palate and other craniofacial and maxillofacial birth defects; or (iv) for treatment of injuries to natural teeth or a fractured jaw due to an accident.

(15) Physical, speech, and functional occupational therapy as medically necessary and provided by appropriate licensed professionals.

(16) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest health care facility qualified to treat a covered illness, injury, or condition, subject to the provisions of the Emergency Medical Systems (EMS) Act.

(17) Outpatient services for diagnosis and treatment of mental and nervous disorders provided that a covered person shall be required to make a copayment not to exceed 50% and that the Plan's payment shall not exceed such amounts as are established by the Board.

(18) Human organ or tissue transplants specified by the Board that are performed at a hospital designated by the Board as a participating transplant center for that specific organ or tissue transplant.

(19) Naprapathic services, as appropriate, provided by a licensed naprapathic practitioner.

c. Exclusions. Covered expenses of the Plan shall not include the following:

(1) Any charge for treatment for cosmetic purposes other than for reconstructive surgery when the service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or surgery for the repair or treatment of a congenital bodily defect to restore normal bodily functions.

(2) Any charge for care that is primarily for rest, custodial, educational, or domiciliary purposes.

(3) Any charge for services in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(4) That part of any charge for room and board or for

1 services rendered or articles prescribed by a physician,
2 dentist, or other health care personnel that exceeds the
3 reasonable and customary charge in the locality or for any
4 services or supplies not medically necessary for the
5 diagnosed injury or illness.

6 (5) Any charge for services or articles the provision
7 of which is not within the scope of licensure of the
8 institution or individual providing the services or
9 articles.

10 (6) Any expense incurred prior to the effective date of
11 coverage by the Plan for the person on whose behalf the
12 expense is incurred.

13 (7) Dental care, dental surgery, dental treatment, any
14 other dental procedure involving the teeth or
15 periodontium, or any dental appliances, including crowns,
16 bridges, implants, or partial or complete dentures, except
17 as specifically provided in paragraph (14) of subsection b
18 of this Section.

19 (8) Eyeglasses, contact lenses, hearing aids or their
20 fitting.

21 (9) Illness or injury due to acts of war.

22 (10) Services of blood donors and any fee for failure
23 to replace the first 3 pints of blood provided to a covered
24 person each policy year.

25 (11) Personal supplies or services provided by a
26 hospital or nursing home, or any other nonmedical or

1 nonprescribed supply or service.
2 (12) Routine maternity charges for a pregnancy, except
3 where added as optional coverage with payment of an
4 additional premium for pregnancy resulting from conception
5 occurring after the effective date of the optional
6 coverage.
7 (13) (Blank).
8 (14) Any expense or charge for services, drugs, or
9 supplies that are: (i) not provided in accord with
10 generally accepted standards of current medical practice;
11 (ii) for procedures, treatments, equipment, transplants,
12 or implants, any of which are investigational,
13 experimental, or for research purposes; (iii)
14 investigative and not proven safe and effective; or (iv)
15 for, or resulting from, a gender transformation operation.
16 (15) Any expense or charge for routine physical
17 examinations or tests except as provided in item (2.5) of
18 subsection b of this Section.
19 (16) Any expense for which a charge is not made in the
20 absence of insurance or for which there is no legal
21 obligation on the part of the patient to pay.
22 (17) Any expense incurred for benefits provided under
23 the laws of the United States and this State, including
24 Medicare, Medicaid, and other medical assistance, maternal
25 and child health services and any other program that is
26 administered or funded by the Department of Human Services,

1 Department of Healthcare and Family Services, or
2 Department of Public Health, military service-connected
3 disability payments, medical services provided for members
4 of the armed forces and their dependents or employees of
5 the armed forces of the United States, and medical services
6 financed on behalf of all citizens by the United States.
7 (18) Any expense or charge for in vitro fertilization,
8 artificial insemination, or any other artificial means
9 used to cause pregnancy.
10 (19) Any expense or charge for oral contraceptives used
11 for birth control or any other temporary birth control
12 measures.
13 (20) Any expense or charge for sterilization or
14 sterilization reversals.
15 (21) Any expense or charge for weight loss programs,
16 exercise equipment, or treatment of obesity, except when
17 certified by a physician as morbid obesity (at least 2
18 times normal body weight).
19 (22) Any expense or charge for acupuncture treatment
20 unless used as an anesthetic agent for a covered surgery.
21 (23) Any expense or charge for or related to organ or
22 tissue transplants other than those performed at a hospital
23 with a Board approved organ transplant program that has
24 been designated by the Board as a preferred or exclusive
25 provider organization for that specific organ or tissue
26 transplant.

(24) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical speciality college for general use within the medical community.

d. Deductibles and coinsurance.

The Plan coverage defined in Section 6 shall provide for a choice of deductibles per individual as authorized by the Board. If 2 individual members of the same family household, who are both covered persons under the Plan, satisfy the same applicable deductibles, no other member of that family who is also a covered person under the Plan shall be required to meet any deductibles for the balance of that calendar year. The deductibles must be applied first to the authorized amount of covered expenses incurred by the covered person. A mandatory coinsurance requirement shall be imposed at the rate authorized by the Board in excess of the mandatory deductible, the coinsurance in the aggregate not to exceed such amounts as are authorized by the Board per annum. At its discretion the Board may, however, offer catastrophic coverages or other policies that provide for larger deductibles with or without coinsurance requirements. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

e. Scope of coverage.

(1) In approving any of the benefit plans to be offered by the Plan, the Board shall establish such benefit levels, deductibles, coinsurance factors, exclusions, and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with health insurance coverage that is provided in the individual market in this State.

(2) The benefit plans approved by the Board may also provide for and employ various cost containment measures and other requirements including, but not limited to, preadmission certification, prior approval, second surgical opinions, concurrent utilization review programs, individual case management, preferred provider organizations, health maintenance organizations, and other cost effective arrangements for paying for covered expenses.

f. Preexisting conditions.

(1) Except for federally eligible individuals qualifying for Plan coverage under Section 15 of this Act or eligible persons who qualify for the waiver authorized in paragraph (3) of this subsection, plan coverage shall exclude charges or expenses incurred during the first 6 months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received during the 6 month period

1 immediately preceding the effective date of coverage.
2 (2) (Blank).
3 (3) Waiver: The preexisting condition exclusions as
4 set forth in paragraph (1) of this subsection shall be
5 waived to the extent to which the eligible person (a) has
6 satisfied similar exclusions under any prior individual
7 health insurance policy that was involuntarily terminated
8 because of the insolvency of the issuer of the policy and
9 (b) has applied for Plan coverage within 90 days following
10 the involuntary termination of that individual health
11 insurance coverage.
12 (4) Waiver: The preexisting condition exclusions as
13 set forth in paragraph (1) of this subsection shall be
14 waived to the extent to which the eligible person (a) has
15 satisfied the exclusion under prior Comprehensive Health
16 Insurance Plan coverage that was involuntarily terminated
17 because of meeting a lower lifetime benefit limit and (b)
18 has reapplied for Plan coverage within 90 days following an
19 increase in the lifetime benefit limit set forth in Section
20 8 of this Act.
21 g. Other sources primary; nonduplication of benefits.
22 (1) The Plan shall be the last payor of benefits
23 whenever any other benefit or source of third party payment
24 is available. Subject to the provisions of subsection e of
25 Section 7, benefits otherwise payable under Plan coverage
26 shall be reduced by all amounts paid or payable by Medicare

or any other government program or through any health insurance coverage or group health plan, whether by insurance, reimbursement, or otherwise, or through any third party liability, settlement, judgment, or award, regardless of the date of the settlement, judgment, or award, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the covered person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, and by all hospital or medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(2) The Plan shall have a cause of action against any covered person or any other person or entity for the recovery of any amount paid to the extent the amount was for treatment, services, or supplies not covered in this Section or in excess of benefits as set forth in this Section.

(3) Whenever benefits are due from the Plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered

person has recovered or may recover damages from a third party or its insurer, the Plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable by the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurer, any benefits that would otherwise be payable except for the provisions of this paragraph (3) shall be paid if payment by or for the third party has not yet been made and the covered person or, if incapable, that person's legal representative agrees in writing to pay back promptly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury. This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

Any amounts due the plan to repay benefits may be deducted from other benefits payable by the Plan after payments by or for the third party are made.

(4) Benefits due from the Plan may be reduced or refused as an offset against any amount otherwise recoverable under this Section.

h. Right of subrogation; recoveries.

(1) Whenever the Plan has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence, or for which an insurer is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for the damages, the Plan shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury. The Plan shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage, including coverage under the Workers' Compensation Act or the Workers' Occupational Diseases Act, without the necessity of assignment of claim or other authorization to secure the right of recovery. To enforce its subrogation right, the Plan may (i) intervene or join in an action or proceeding brought by the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurer that may be liable or (ii) institute and prosecute legal proceedings against any third party or the third party's insurer that may be liable

1 for the sickness or injury in an appropriate court either
2 in the name of the Plan or in the name of the covered
3 person or his personal representative, including his
4 guardian, conservator, estate, dependents, or survivors.
5 (2) If any action or claim is brought by or on behalf
6 of a covered person against a third party or the third
7 party's insurer, the covered person or his personal
8 representative, including his guardian, conservator,
9 estate, dependents, or survivors, shall notify the Plan by
10 personal service or registered mail of the action or claim
11 and of the name of the court in which the action or claim
12 is brought, filing proof thereof in the action or claim.
13 The Plan may, at any time thereafter, join in the action or
14 claim upon its motion so that all orders of court after
15 hearing and judgment shall be made for its protection. No
16 release or settlement of a claim for damages and no
17 satisfaction of judgment in the action shall be valid
18 without the written consent of the Plan to the extent of
19 its interest in the settlement or judgment and of the
20 covered person or his personal representative.
21 (3) In the event that the covered person or his
22 personal representative fails to institute a proceeding
23 against any appropriate third party before the fifth month
24 before the action would be barred, the Plan may, in its own
25 name or in the name of the covered person or personal
26 representative, commence a proceeding against any

1 appropriate third party for the recovery of damages on
2 account of any sickness, injury, or death to the covered
3 person. The covered person shall cooperate in doing what is
4 reasonably necessary to assist the Plan in any recovery and
5 shall not take any action that would prejudice the Plan's
6 right to recovery. The Plan shall pay to the covered person
7 or his personal representative all sums collected from any
8 third party by judgment or otherwise in excess of amounts
9 paid in benefits under the Plan and amounts paid or to be
10 paid as costs, attorneys fees, and reasonable expenses
11 incurred by the Plan in making the collection or enforcing
12 the judgment.
13 (4) In the event that a covered person or his personal
14 representative, including his guardian, conservator,
15 estate, dependents, or survivors, recovers damages from a
16 third party for sickness or injury caused to the covered
17 person, the covered person or the personal representative
18 shall pay to the Plan from the damages recovered the amount
19 of benefits paid or to be paid on behalf of the covered
20 person.
21 (5) When the action or claim is brought by the covered
22 person alone and the covered person incurs a personal
23 liability to pay attorney's fees and costs of litigation,
24 the Plan's claim for reimbursement of the benefits provided
25 to the covered person shall be the full amount of benefits
26 paid to or on behalf of the covered person under this Act

1 less a pro rata share that represents the Plan's reasonable
2 share of attorney's fees paid by the covered person and
3 that portion of the cost of litigation expenses determined
4 by multiplying by the ratio of the full amount of the
5 expenditures to the full amount of the judgement, award, or
6 settlement.

7 (6) In the event of judgment or award in a suit or
8 claim against a third party or insurer, the court shall
9 first order paid from any judgement or award the reasonable
10 litigation expenses incurred in preparation and
11 prosecution of the action or claim, together with
12 reasonable attorney's fees. After payment of those
13 expenses and attorney's fees, the court shall apply out of
14 the balance of the judgment or award an amount sufficient
15 to reimburse the Plan the full amount of benefits paid on
16 behalf of the covered person under this Act, provided the
17 court may reduce and apportion the Plan's portion of the
18 judgement proportionate to the recovery of the covered
19 person. The burden of producing evidence sufficient to
20 support the exercise by the court of its discretion to
21 reduce the amount of a proven charge sought to be enforced
22 against the recovery shall rest with the party seeking the
23 reduction. The court may consider the nature and extent of
24 the injury, economic and non-economic loss, settlement
25 offers, comparative negligence as it applies to the case at
26 hand, hospital costs, physician costs, and all other

appropriate costs. The Plan shall pay its pro rata share of the attorney fees based on the Plan's recovery as it compares to the total judgment. Any reimbursement rights of the Plan shall take priority over all other liens and charges existing under the laws of this State with the exception of any attorney liens filed under the Attorneys Lien Act.

(7) The Plan may compromise or settle and release any claim for benefits provided under this Act or waive any claims for benefits, in whole or in part, for the convenience of the Plan or if the Plan determines that collection would result in undue hardship upon the covered person.

(Source: P.A. 95-547, eff. 8-29-07; 96-791, eff. 9-25-09.)

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