SB2314

LRB09916031HLH40349b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB2314

Introduced 1/27/2016, by Sen. Sue Rezin

SYNOPSIS AS INTRODUCED:

5 ILCS 375/3	from Ch. 127, par. 523
5 ILCS 375/5	from Ch. 127, par. 525
5 ILCS 375/8	from Ch. 127, par. 528
5 ILCS 375/10	from Ch. 127, par. 530

Amends the State Employees Group Insurance Act of 1971. Provides that State benefit recipients are eligible for the basic program of health benefits, but are not eligible for group life insurance benefits or other optional coverages or benefits available to employees. Provides that the term "State benefit recipient" means a person in the service of a department who: (1) is not a member; (2) receives salary or wages for personal service rendered to the department; and (3) is employed in a position normally requiring actual performance of duty during not less than 30 hours per week. Provides that the term "State benefit recipient" does not include any person deemed to be an independent contractor or any person who is employed by any State-contracted vendor and is performing services pursuant to the contract between the vendor and the State.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning State government.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Sections 3, 5, 8, and 10 as follows:

(5 ILCS 375/3) (from Ch. 127, par. 523)

Sec. 3. Definitions. Unless the context otherwise requires, the following words and phrases as used in this Act shall have the following meanings. The Department may define these and other words and phrases separately for the purpose of implementing specific programs providing benefits under this Act.

(a) "Administrative service organization" means any person, firm or corporation experienced in the handling of claims which is fully qualified, financially sound and capable of meeting the service requirements of a contract of administration executed with the Department.

(b) "Annuitant" means (1) an employee who retires, or has retired, on or after January 1, 1966 on an immediate annuity under the provisions of Articles 2, 14 (including an employee who has elected to receive an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code in lieu of an annuity), 15 (including an employee

who has retired under the optional retirement program established under Section 15-158.2), paragraphs (2), (3), or (5) of Section 16-106, or Article 18 of the Illinois Pension Code; (2) any person who was receiving group insurance coverage under this Act as of March 31, 1978 by reason of his status as an annuitant, even though the annuity in relation to which such coverage was provided is a proportional annuity based on less than the minimum period of service required for a retirement annuity in the system involved; (3) any person not otherwise covered by this Act who has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code; (4) the spouse of any person who is receiving a retirement annuity under Article 18 of the Illinois Pension Code and who is covered under a group health insurance program sponsored by a governmental employer other than the State of Illinois and who has irrevocably elected to waive his or her coverage under this Act and to have his or her spouse considered as the "annuitant" under this Act and not as a "dependent"; or (5) an employee who retires, or has retired, from a qualified position, as determined according to rules promulgated by the Director, under a qualified local government, a qualified rehabilitation facility, a qualified domestic violence shelter or service, or a qualified child advocacy center. (For definition of "retired employee", see (p) post).

(b-5) (Blank).

(b-6) (Blank).

(b-7) (Blank).

(c) "Carrier" means (1) an insurance company, a corporation organized under the Limited Health Service Organization Act or the Voluntary Health Services Plan Act, a partnership, or other nongovernmental organization, which is authorized to do group life or group health insurance business in Illinois, or (2) the State of Illinois as a self-insurer.

(d) "Compensation" means salary or wages payable on a regular payroll by the State Treasurer on a warrant of the State Comptroller out of any State, trust or federal fund, or by the Governor of the State through a disbursing officer of the State out of a trust or out of federal funds, or by any Department out of State, trust, federal or other funds held by the State Treasurer or the Department, to any person for personal services currently performed, and ordinary or accidental disability benefits under Articles 2, 14, 15 (including ordinary or accidental disability benefits under the optional retirement program established under Section 15-158.2), paragraphs (2), (3), or (5) of Section 16-106, or Article 18 of the Illinois Pension Code, for disability incurred after January 1, 1966, or benefits payable under the Workers' Compensation or Occupational Diseases Act or benefits payable under a sick pay plan established in accordance with Section 36 of the State Finance Act. "Compensation" also means

salary or wages paid to an employee of any qualified local government, qualified rehabilitation facility, qualified domestic violence shelter or service, or qualified child advocacy center.

(e) "Commission" means the State Employees Group Insurance Advisory Commission authorized by this Act. Commencing July 1, 1984, "Commission" as used in this Act means the Commission on Government Forecasting and Accountability as established by the Legislative Commission Reorganization Act of 1984.

(f) "Contributory", when referred to as contributory coverage, shall mean optional coverages or benefits elected by the member toward the cost of which such member makes contribution, or which are funded in whole or in part through the acceptance of a reduction in earnings or the foregoing of an increase in earnings by an employee, as distinguished from noncontributory coverage or benefits which are paid entirely by the State of Illinois without reduction of the member's salary.

(g) "Department" means any department, institution, board, commission, officer, court or any agency of the State government receiving appropriations and having power to certify payrolls to the Comptroller authorizing payments of salary and wages against such appropriations as are made by the General Assembly from any State fund, or against trust funds held by the State Treasurer and includes boards of trustees of the retirement systems created by Articles 2, 14, 15, 16 and 18 of the Illinois Pension Code. "Department" also includes the

Illinois Comprehensive Health Insurance Board, the Board of Examiners established under the Illinois Public Accounting Act, and the Illinois Finance Authority.

(h) "Dependent", when the term is used in the context of the health and life plan, means a member's spouse and any child (1) from birth to age 26 including an adopted child, a child who lives with the member from the time of the filing of a petition for adoption until entry of an order of adoption, a stepchild or adjudicated child, or a child who lives with the member if such member is a court appointed guardian of the child or (2) age 19 or over who has a mental or physical disability from a cause originating prior to the age of 19 (age 26 if enrolled as an adult child dependent). For the health plan only, the term "dependent" also includes (1) any person enrolled prior to the effective date of this Section who is dependent upon the member to the extent that the member may claim such person as a dependent for income tax deduction purposes and (2) any person who has received after June 30, 2000 an organ transplant and who is financially dependent upon the member and eligible to be claimed as a dependent for income tax purposes. A member requesting to cover any dependent must provide documentation as requested by the Department of Central Management Services and file with the Department any and all forms required by the Department.

(i) "Director" means the Director of the Illinois Department of Central Management Services.

(j) "Eligibility period" means the period of time a member has to elect enrollment in programs or to select benefits without regard to age, sex or health.

(k) "Employee" means and includes each officer or employee in the service of a department who (1) receives his compensation for service rendered to the department on a warrant issued pursuant to a payroll certified by a department or on a warrant or check issued and drawn by a department upon a trust, federal or other fund or on a warrant issued pursuant to a payroll certified by an elected or duly appointed officer of the State or who receives payment of the performance of personal services on a warrant issued pursuant to a payroll certified by a Department and drawn by the Comptroller upon the State Treasurer against appropriations made by the General Assembly from any fund or against trust funds held by the State Treasurer, and (2) is employed full-time or part-time in a position normally requiring actual performance of duty during not less than 1/2 of a normal work period, as established by the Director in cooperation with each department, except that persons elected by popular vote will be considered employees during the entire term for which they are elected regardless of hours devoted to the service of the State, and (3) except that "employee" does not include any person who is not eligible by reason of such person's employment to participate in one of the State retirement systems under Articles 2, 14, 15 (either the regular Article 15 system or the optional retirement program

established under Section 15-158.2) or 18, or under paragraph (2), (3), or (5) of Section 16-106, of the Illinois Pension Code, but such term does include persons who are employed during the 6 month qualifying period under Article 14 of the Illinois Pension Code. Such term also includes any person who (1) after January 1, 1966, is receiving ordinary or accidental disability benefits under Articles 2, 14, 15 (including ordinary or accidental disability benefits under the optional retirement program established under Section 15-158.2), paragraphs (2), (3), or (5) of Section 16-106, or Article 18 of the Illinois Pension Code, for disability incurred after January 1, 1966, (2) receives total permanent or total temporary disability under the Workers' Compensation Act or Occupational Disease Act as a result of injuries sustained or illness contracted in the course of employment with the State of Illinois, or (3) is not otherwise covered under this Act and has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code. However, a person who satisfies the criteria of the foregoing definition of "employee" except that such person is made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code is also an "employee" for the purposes of this Act. "Employee" also includes any person receiving or eligible for benefits under a sick pay plan established in

accordance with Section 36 of the State Finance Act. "Employee" also includes (i) each officer or employee in the service of a qualified local government, including persons appointed as trustees of sanitary districts regardless of hours devoted to the service of the sanitary district, (ii) each employee in the service of a qualified rehabilitation facility, (iii) each full-time employee in the service of a qualified domestic violence shelter or service, and (iv) each full-time employee in the service of a qualified child advocacy center, as determined according to rules promulgated by the Director.

(l) "Member" means an employee, annuitant, retired employee or survivor. In the case of an annuitant or retired employee who first becomes an annuitant or retired employee on or after the effective date of this amendatory Act of the 97th General Assembly, the individual must meet the minimum vesting requirements of the applicable retirement system in order to be eligible for group insurance benefits under that system. In the case of a survivor who first becomes a survivor on or after the effective date of this amendatory Act of the 97th General Assembly, the deceased employee, annuitant, or retired employee upon whom the annuity is based must have been eligible to participate in the group insurance system under the applicable retirement system in order for the survivor to be eligible for group insurance benefits under that system. <u>References to the term "member" include State benefit recipients, but only with respect to the basic program of group</u>

health benefits and not for the purposes of enrollment in any group life insurance benefits or optional coverages or benefits.

(m) "Optional coverages or benefits" means those coverages or benefits available to the member on his or her voluntary election, and at his or her own expense.

(n) "Program" means the group life insurance, health benefits and other employee benefits designed and contracted for by the Director under this Act.

(o) "Health plan" means a health benefits program offered by the State of Illinois for persons eligible for the plan.

(p) "Retired employee" means any person who would be an annuitant as that term is defined herein but for the fact that such person retired prior to January 1, 1966. Such term also includes any person formerly employed by the University of Illinois in the Cooperative Extension Service who would be an annuitant but for the fact that such person was made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code.

(q) "Survivor" means a person receiving an annuity as a survivor of an employee or of an annuitant. "Survivor" also includes: (1) the surviving dependent of a person who satisfies the definition of "employee" except that such person is made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the

Illinois Pension Code; (2) the surviving dependent of any person formerly employed by the University of Illinois in the Cooperative Extension Service who would be an annuitant except for the fact that such person was made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code; and (3) the surviving dependent of a person who was an annuitant under this Act by virtue of receiving an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code.

(q-2) "SERS" means the State Employees' Retirement System of Illinois, created under Article 14 of the Illinois Pension Code.

(q-2.1) "State benefit recipient" means a person in the service of a department who: (1) is not a member, as defined in this Section; (2) receives salary or wages for personal service rendered to the department; and (3) is employed in a position normally requiring actual performance of duty during not less than 30 hours per week, except that "state benefit recipient" does not include any person deemed to be an independent contractor or any person who is employed by any State-contracted vendor and is performing services pursuant to the contract between the vendor and the State.

(q-3) "SURS" means the State Universities Retirement System, created under Article 15 of the Illinois Pension Code.

(q-4) "TRS" means the Teachers' Retirement System of the

State of Illinois, created under Article 16 of the Illinois Pension Code.

(q-5) (Blank).

(q-6) (Blank).

(q-7) (Blank).

(r) "Medical services" means the services provided within the scope of their licenses by practitioners in all categories licensed under the Medical Practice Act of 1987.

(s) "Unit of local government" means any county, municipality, township, school district (including a combination of school districts under the Intergovernmental Cooperation Act), special district or other unit, designated as a unit of local government by law, which exercises limited governmental powers or powers in respect to limited governmental subjects, any not-for-profit association with a membership that primarily includes townships and township officials, that has duties that include provision of research service, dissemination of information, and other acts for the purpose of improving township government, and that is funded wholly or partly in accordance with Section 85-15 of the Township Code; any not-for-profit corporation or association, with a membership consisting primarily of municipalities, that operates its own utility system, and provides research, training, dissemination of information, or other acts to promote cooperation between and among municipalities that provide utility services and for the advancement of the goals

and purposes of its membership; the Southern Illinois Collegiate Common Market, which is a consortium of higher education institutions in Southern Illinois; the Illinois Association of Park Districts; and any hospital provider that is owned by a county that has 100 or fewer hospital beds and has not already joined the program. "Qualified local government" means a unit of local government approved by the Director and participating in a program created under subsection (i) of Section 10 of this Act.

(t) "Qualified rehabilitation facility" means any not-for-profit organization that is accredited by the Commission on Accreditation of Rehabilitation Facilities or certified by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities) to provide services to persons with disabilities and which receives funds from the State of Illinois for providing those services, approved by the Director and participating in a program created under subsection (j) of Section 10 of this Act.

(u) "Qualified domestic violence shelter or service" means any Illinois domestic violence shelter or service and its administrative offices funded by the Department of Human Services (as successor to the Illinois Department of Public Aid), approved by the Director and participating in a program created under subsection (k) of Section 10.

(v) "TRS benefit recipient" means a person who:

(1) is not a "member" as defined in this Section; and

(2) is receiving a monthly benefit or retirement annuity under Article 16 of the Illinois Pension Code; and

(3) either (i) has at least 8 years of creditable service under Article 16 of the Illinois Pension Code, or (ii) was enrolled in the health insurance program offered under that Article on January 1, 1996, or (iii) is the survivor of a benefit recipient who had at least 8 years of creditable service under Article 16 of the Illinois Pension Code or was enrolled in the health insurance program offered under that Article on the effective date of this amendatory Act of 1995, or (iv) is a recipient or survivor of a recipient of a disability benefit under Article 16 of the Illinois Pension Code.

(w) "TRS dependent beneficiary" means a person who:

(1) is not a "member" or "dependent" as defined in this Section; and

(2) is a TRS benefit recipient's: (A) spouse, (B) dependent parent who is receiving at least half of his or her support from the TRS benefit recipient, or (C) natural, step, adjudicated, or adopted child who is (i) under age 26, (ii) was, on January 1, 1996, participating as a dependent beneficiary in the health insurance program offered under Article 16 of the Illinois Pension Code, or (iii) age 19 or over who has a mental or physical disability from a cause originating prior to the age of 19

(age 26 if enrolled as an adult child).

"TRS dependent beneficiary" does not include, as indicated under paragraph (2) of this subsection (w), a dependent of the survivor of a TRS benefit recipient who first becomes a dependent of a survivor of a TRS benefit recipient on or after the effective date of this amendatory Act of the 97th General Assembly unless that dependent would have been eligible for coverage as a dependent of the deceased TRS benefit recipient upon whom the survivor benefit is based.

(x) "Military leave" refers to individuals in basic training for reserves, special/advanced training, annual training, emergency call up, activation by the President of the United States, or any other training or duty in service to the United States Armed Forces.

(y) (Blank).

(z) "Community college benefit recipient" means a person who:

(1) is not a "member" as defined in this Section; and

(2) is receiving a monthly survivor's annuity or retirement annuity under Article 15 of the Illinois Pension Code; and

(3) either (i) was a full-time employee of a community college district or an association of community college boards created under the Public Community College Act (other than an employee whose last employer under Article 15 of the Illinois Pension Code was a community college

district subject to Article VII of the Public Community College Act) and was eligible to participate in a group health benefit plan as an employee during the time of employment with a community college district (other than a community college district subject to Article VII of the Public Community College Act) or an association of community college boards, or (ii) is the survivor of a person described in item (i).

(aa) "Community college dependent beneficiary" means a person who:

(1) is not a "member" or "dependent" as defined in this Section; and

(2) is a community college benefit recipient's: (A) spouse, (B) dependent parent who is receiving at least half of his or her support from the community college benefit recipient, or (C) natural, step, adjudicated, or adopted child who is (i) under age 26, or (ii) age 19 or over and has a mental or physical disability from a cause originating prior to the age of 19 (age 26 if enrolled as an adult child).

"Community college dependent beneficiary" does not include, as indicated under paragraph (2) of this subsection (aa), a dependent of the survivor of a community college benefit recipient who first becomes a dependent of a survivor of a community college benefit recipient on or after the effective date of this amendatory Act of the 97th General

Assembly unless that dependent would have been eligible for coverage as a dependent of the deceased community college benefit recipient upon whom the survivor annuity is based.

(bb) "Qualified child advocacy center" means any Illinois child advocacy center and its administrative offices funded by the Department of Children and Family Services, as defined by the Children's Advocacy Center Act (55 ILCS 80/), approved by the Director and participating in a program created under subsection (n) of Section 10.

(Source: P.A. 98-488, eff. 8-16-13; 99-143, eff. 7-27-15.)

(5 ILCS 375/5) (from Ch. 127, par. 525)

Sec. 5. Employee benefits; declaration of State policy. The General Assembly declares that it is the policy of the State and in the best interest of the State to assure quality benefits to members and their dependents under this Act. The implementation of this policy depends upon, among other things, stability and continuity of coverage, care, and services under benefit programs for members and their dependents. Specifically, but without limitation, members should have continued access, on substantially similar terms and conditions, to trusted family health care providers with whom they have developed long-term relationships through a benefit program under this Act. Therefore, the Director must administer this Act consistent with that State policy, but may consider affordability, cost of coverage and care, and competition among

health insurers and providers. All contracts for provision of employee benefits, including those portions of any proposed collective bargaining agreement that would require implementation through contracts entered into under this Act, are subject to the following requirements:

(i) By April 1 of each year, the Director must report and provide information to the Commission concerning the status of the employee benefits program to be offered for the next fiscal year. Information includes, but is not limited to, documents, reports of negotiations, bid invitations, requests for proposals, specifications, copies of proposed and final contracts or agreements, and any other materials concerning contracts or agreements for the employee benefits program. By the first of each month thereafter, the Director must provide updated, and any new, information to the Commission until the employee benefits program for the next fiscal year is determined. In addition to these monthly reporting requirements, at any time the Commission makes a written request, the Director must promptly, but in no event later than 5 business days after receipt of the request, provide to the Commission any additional requested information in the possession of the Director concerning employee benefits programs. The Commission may waive any of the reporting requirements of this item (i) upon the written request by the Director. Any waiver granted under this item (i) must be in writing.

Nothing in this item is intended to abrogate any attorney-client privilege.

(ii) Within 30 days after notice of the awarding or letting of a contract has appeared in the Illinois Procurement Bulletin in accordance with subsection (b) of Section 15-25 of the Illinois Procurement Code, the Commission may request in writing from the Director and the Director shall promptly, but in no event later than 5 business days after receipt of the request, provide to the Commission information in the possession of the Director concerning the proposed contract. Nothing in this item is intended to waive or abrogate any privilege or right of confidentiality authorized by law.

(iii) Except as otherwise provided in this item (iii), no contract subject to this Section may be entered into until the 30-day period described in item (ii) has expired, unless the Director requests in writing that the Commission waive the period and the Commission grants the waiver in writing. This item (iii) does not apply to any contract entered into after the effective date of this amendatory Act of the 98th General Assembly and through January 1, 2014 to provide a program of group health benefits for Medicare-primary members and their Medicare-primary dependents that is comparable in stability and continuity of coverage, care, and services to the program of health benefits offered to other members and their dependents

under this Act.

(iv) If the Director seeks to make any substantive modification to any provision of a proposed contract after it is submitted to the Commission in accordance with item (ii), the modified contract shall be subject to the requirements of items (ii) and (iii) unless the Commission agrees, in writing, to a waiver of those requirements with respect to the modified contract.

(v) By the date of the beginning of the annual benefit choice period, the Director must transmit to the Commission a copy of each final contract or agreement for the employee benefits program to be offered for the next fiscal year. The annual benefit choice period for an employee benefits program must begin on May 1 of the fiscal year preceding the year for which the program is to be offered. If, however, in any such preceding fiscal year collective bargaining over employee benefit programs for the next fiscal year remains pending on April 15, the beginning date of the annual benefit choice period shall be not later than 15 days after ratification of the collective bargaining agreement.

(vi) The Director must provide the reports, information, and contracts required under items (i), (ii), (iv), and (v) by electronic or other means satisfactory to the Commission. Reports, information, and contracts in the possession of the Commission pursuant to items (i), (ii),

(iv), and (v) are exempt from disclosure by the Commission and its members and employees under the Freedom of Information Act. Reports, information, and contracts received by the Commission pursuant to items (i), (ii), (iv), and (v) must be kept confidential by and may not be disclosed or used by the Commission or its members or employees if such disclosure or use could compromise the fairness or integrity of the procurement, bidding, or contract process. Commission meetings, or portions of Commission meetings, in which reports, information, and contracts received by the Commission pursuant to items (i), (ii), (iv), and (v) are discussed must be closed if disclosure or use of the report or information could compromise the fairness or integrity of the procurement, bidding, or contract process.

All contracts entered into under this Section are subject to appropriation and shall comply with Section 20-60(b) of the Illinois Procurement Code (30 ILCS 500/20-60(b)).

The Director shall contract or otherwise make available group life insurance~~, health benefits~~ and other employee benefits to eligible members and, where elected, their eligible dependents. The Director shall contract or otherwise make available health benefits to eligible State benefit recipients, members, and, where elected, their eligible dependents. Any contract or, if applicable, contracts or other arrangement for provision of benefits shall be on terms

consistent with State policy and based on, but not limited to, such criteria as administrative cost, service capabilities of the carrier or other contractor and premiums, fees or charges as related to benefits.

Notwithstanding any other provisions of this Act, by January 1, 2014, the Department of Central Management Services, in consultation with and subject to the approval of the Chief Procurement Officer, shall contract or make otherwise available a program of group health benefits for Medicare-primary members and their Medicare-primary dependents. The Director may procure a single contract or multiple contracts that provide a program of group health benefits that is comparable in stability and continuity of coverage, care, and services to the program of health benefits offered to other members and their dependents under this Act. The initial procurement of a contract or contracts under this paragraph is not subject to the provisions of the Illinois Procurement Code, except for Sections 20-60, 20-65, 20-70, and 20-160 and Article 50 of that Code, provided that the Chief Procurement Officer may, in writing with justification, waive any certification required under Article 50.

The Director may prepare and issue specifications for group life insurance, health benefits, other employee benefits and administrative services for the purpose of receiving proposals from interested parties.

The Director is authorized to execute a contract, or

contracts, for the programs of group life insurance, health benefits, other employee benefits and administrative services authorized by this Act (including, without limitation, prescription drug benefits). All of the benefits provided under this Act may be included in one or more contracts, or the benefits may be classified into different types with each type included under one or more similar contracts with the same or different companies.

The term of any contract may not extend beyond 5 fiscal years. Upon recommendation of the Commission, the Director may exercise renewal options of the same contract for up to a period of 5 years. Any increases in premiums, fees or charges requested by a contractor whose contract may be renewed pursuant to a renewal option contained therein, must be justified on the basis of (1) audited experience data, (2) increases in the costs of health care services provided under the contract, (3) contractor performance, (4) increases in contractor responsibilities, or (5) any combination thereof.

Any contractor shall agree to abide by all requirements of this Act and Rules and Regulations promulgated and adopted thereto; to submit such information and data as may from time to time be deemed necessary by the Director for effective administration of the provisions of this Act and the programs established hereunder, and to fully cooperate in any audit.

(Source: P.A. 98-19, eff. 6-10-13.)

(5 ILCS 375/8) (from Ch. 127, par. 528)

Sec. 8. Eligibility.

(a) Each employee eligible under the provisions of this Act and any rules and regulations promulgated and adopted hereunder by the Director shall become immediately eligible and covered for all benefits available under the programs. Employees electing coverage for eligible dependents shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director, including the completion and submission of all documentation and forms required by the Director.

(1) Every member originally eligible to elect dependent coverage, but not electing it during the original eligibility period, may subsequently obtain dependent coverage only in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

(2) Members described above being transferred from previous coverage towards which the State has been contributing shall be transferred regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled.

(3) Eligible and covered members that are eligible for

coverage as dependents except for the fact of being members shall be transferred to, and covered under, dependent status regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled upon cessation of member status and the election of dependent coverage by a member eligible to elect that coverage.

(b) New employees shall be immediately insured for the basic group life insurance and covered by the program of health benefits on the first day of active State service. Optional life insurance coverage one to 4 times the basic amount, if elected during the relevant eligibility period, will become effective on the date of employment. Optional life insurance coverage exceeding 4 times the basic amount and all life insurance amounts applied for after the eligibility period will be effective, subject to satisfactory evidence of insurability when applicable, or other necessary qualifications, pursuant to the requirements of the applicable benefit program, unless there is a change in status that would confer new eligibility for change of enrollment under rules established supplementing this Act, in which event application must be made within the new eligibility period.

(c) As to the group health benefits program contracted to begin or continue after June 30, 1973, each annuitant, survivor, and retired employee shall become immediately

eligible for all benefits available under that program. Each annuitant, survivor, and retired employee shall have coverage effective immediately, provided that the election is properly filed in accordance with the required filing dates and procedures specified by the Director, including the completion and submission of all documentation and forms required by the Director. Annuitants, survivors, and retired employees may elect coverage for eligible dependents and shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director, except that, for a survivor, the dependent sought to be added on or after the effective date of this amendatory Act of the 97th General Assembly must have been eligible for coverage as a dependent under the deceased member upon whom the survivor's annuity is based in order to be eligible for coverage under the survivor.

Except as otherwise provided in this Act, where husband and wife are both eligible members, each shall be enrolled as a member and coverage on their eligible dependent children, if any, may be under the enrollment and election of either.

Regardless of other provisions herein regarding late enrollment or other qualifications, as appropriate, the Director may periodically authorize open enrollment periods for each of the benefit programs at which time each member may elect enrollment or change of enrollment without regard to age, sex, health, or other qualification under the conditions as may

be prescribed in rules and regulations supplementing this Act. Special open enrollment periods may be declared by the Director for certain members only when special circumstances occur that affect only those members.

(d) Beginning with fiscal year 2003 and for all subsequent years, eligible members may elect not to participate in the program of health benefits as defined in this Act. The election must be made during the annual benefit choice period, subject to the conditions in this subsection.

(1) Members must furnish proof of health benefit coverage, either comprehensive major medical coverage or comprehensive managed care plan, from a source other than the Department of Central Management Services in order to elect not to participate in the program.

(2) Members may re-enroll in the Department of Central Management Services program of health benefits upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions, provided that there was not a break in coverage of more than 63 days.

(3) Members may also re-enroll in the program of health benefits during any annual benefit choice period, without evidence of insurability.

(4) Members who elect not to participate in the program of health benefits shall be furnished a written explanation

of the requirements and limitations for the election not to participate in the program and for re-enrolling in the program. The explanation shall also be included in the annual benefit choice options booklets furnished to members.

(d-5) Beginning July 1, 2005, the Director may establish a program of financial incentives to encourage annuitants receiving a retirement annuity, but who are not eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in accordance with the requirements set forth under subsection (d). The financial incentives provided to these annuitants under the program may not exceed $150 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(d-6) Beginning July 1, 2013, the Director may establish a program of financial incentives to encourage annuitants with 20 or more years of creditable service but who are not eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in

accordance with the requirements set forth under subsection (d). The program established under this subsection (d-6) may include a prorated incentive for annuitants with fewer than 20 years of creditable service, as determined by the Director. The financial incentives provided to these annuitants under this program may not exceed $500 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(e) Notwithstanding any other provision of this Act or the rules adopted under this Act, if a person participating in the program of health benefits as the dependent spouse of an eligible member becomes an annuitant, the person may elect, at the time of becoming an annuitant or during any subsequent annual benefit choice period, to continue participation as a dependent rather than as an eligible member for as long as the person continues to be an eligible dependent. In order to be eligible to make such an election, the person must have been enrolled as a dependent under the program of health benefits for no less than one year prior to becoming an annuitant.

An eligible member who has elected to participate as a dependent may re-enroll in the program of health benefits as an eligible member (i) during any subsequent annual benefit choice period or (ii) upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions.

A person who elects to participate in the program of health benefits as a dependent rather than as an eligible member shall be furnished a written explanation of the consequences of electing to participate as a dependent and the conditions and procedures for re-enrolling as an eligible member. The explanation shall also be included in the annual benefit choice options booklet furnished to members.

(f) State benefit recipients shall be eligible to enroll in the program of health benefits on the first day of active State service. State benefit recipients who were not eligible to enroll in the program of health benefits immediately prior to the effective date of this amendatory Act of the 99th General Assembly, but who became eligible to enroll in the program of health benefits as a result of this amendatory Act of the 99th General Assembly, may elect to participate in coverage in accordance with procedures specified by the Director or during any annual benefit choice period. Notwithstanding any other provision of this Act, State benefit recipients shall be eligible only for the program of health benefits and shall not be eligible for group life insurance benefits or other optional coverages or benefits available to employees.

(Source: P.A. 97-668, eff. 1-13-12; 98-19, eff. 6-10-13.)

(5 ILCS 375/10) (from Ch. 127, par. 530)

Sec. 10. Contributions by the State and members.

(a) The State shall pay the cost of basic non-contributory

group life insurance and, subject to member paid contributions set by the Department or required by this Section and except as provided in this Section, the basic program of group health benefits on each eligible member, except a member, not otherwise covered by this Act, who has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, and part of each eligible member's and retired member's premiums for health insurance coverage for enrolled dependents as provided by Section 9. The State shall pay the cost of the basic program of group health benefits only after benefits are reduced by the amount of benefits covered by Medicare for all members and dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, except that such reduction in benefits shall apply only to those members and dependents who (1) first become eligible for such Medicare coverage on or after July 1, 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the program on or after July 1, 1992; or (3) remain eligible for, but no longer receive Medicare coverage which they had been receiving on or after July 1, 1992. The Department may determine the aggregate level of the State's contribution on the basis of actual cost of medical services adjusted for age, sex or geographic or other demographic characteristics which affect

the costs of such programs.

The cost of participation in the basic program of group health benefits for the dependent or survivor of a living or deceased retired employee who was formerly employed by the University of Illinois in the Cooperative Extension Service and would be an annuitant but for the fact that he or she was made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code shall not be greater than the cost of participation that would otherwise apply to that dependent or survivor if he or she were the dependent or survivor of an annuitant under the State Universities Retirement System.

(a-1) (Blank).

(a-2) (Blank).

(a-3) (Blank).

(a-4) (Blank).

(a-5) (Blank).

(a-6) (Blank).

(a-7) (Blank).

(a-8) Any annuitant, survivor, or retired employee may waive or terminate coverage in the program of group health benefits. Any such annuitant, survivor, or retired employee who has waived or terminated coverage may enroll or re-enroll in the program of group health benefits only during the annual benefit choice period, as determined by the Director; except that in the event of termination of coverage due to nonpayment

of premiums, the annuitant, survivor, or retired employee may not re-enroll in the program.

(a-8.5) Beginning on the effective date of this amendatory Act of the 97th General Assembly, the Director of Central Management Services shall, on an annual basis, determine the amount that the State shall contribute toward the basic program of group health benefits on behalf of annuitants (including individuals who (i) participated in the General Assembly Retirement System, the State Employees' Retirement System of Illinois, the State Universities Retirement System, the Teachers' Retirement System of the State of Illinois, or the Judges Retirement System of Illinois and (ii) qualify as annuitants under subsection (b) of Section 3 of this Act), survivors (including individuals who (i) receive an annuity as a survivor of an individual who participated in the General Assembly Retirement System, the State Employees' Retirement System of Illinois, the State Universities Retirement System, the Teachers' Retirement System of the State of Illinois, or the Judges Retirement System of Illinois and (ii) qualify as survivors under subsection (q) of Section 3 of this Act), and retired employees (as defined in subsection (p) of Section 3 of this Act). The remainder of the cost of coverage for each annuitant, survivor, or retired employee, as determined by the Director of Central Management Services, shall be the responsibility of that annuitant, survivor, or retired employee.

Contributions required of annuitants, survivors, and retired employees shall be the same for all retirement systems and shall also be based on whether an individual has made an election under Section 15-135.1 of the Illinois Pension Code. Contributions may be based on annuitants', survivors', or retired employees' Medicare eligibility, but may not be based on Social Security eligibility.

(a-9) No later than May 1 of each calendar year, the Director of Central Management Services shall certify in writing to the Executive Secretary of the State Employees' Retirement System of Illinois the amounts of the Medicare supplement health care premiums and the amounts of the health care premiums for all other retirees who are not Medicare eligible.

A separate calculation of the premiums based upon the actual cost of each health care plan shall be so certified.

The Director of Central Management Services shall provide to the Executive Secretary of the State Employees' Retirement System of Illinois such information, statistics, and other data as he or she may require to review the premium amounts certified by the Director of Central Management Services.

The Department of Central Management Services, or any successor agency designated to procure healthcare contracts pursuant to this Act, is authorized to establish funds, separate accounts provided by any bank or banks as defined by the Illinois Banking Act, or separate accounts provided by any

savings and loan association or associations as defined by the Illinois Savings and Loan Act of 1985 to be held by the Director, outside the State treasury, for the purpose of receiving the transfer of moneys from the Local Government Health Insurance Reserve Fund. The Department may promulgate rules further defining the methodology for the transfers. Any interest earned by moneys in the funds or accounts shall inure to the Local Government Health Insurance Reserve Fund. The transferred moneys, and interest accrued thereon, shall be used exclusively for transfers to administrative service organizations or their financial institutions for payments of claims to claimants and providers under the self-insurance health plan. The transferred moneys, and interest accrued thereon, shall not be used for any other purpose including, but not limited to, reimbursement of administration fees due the administrative service organization pursuant to its contract or contracts with the Department.

(b) State employees who become eligible for this program on or after January 1, 1980 in positions normally requiring actual performance of duty not less than 1/2 of a normal work period but not equal to <u>at least 30 hours per week</u> ~~that of a normal work period~~, shall be given the option of participating in the available program. If the employee elects coverage, the State shall contribute on behalf of such employee to the cost of the employee's benefit and any applicable dependent supplement, that sum which bears the same percentage as that percentage of

time the employee regularly works when compared to normal work period.

(c) The basic non-contributory coverage from the basic program of group health benefits shall be continued for each employee not in pay status or on active service by reason of (1) leave of absence due to illness or injury, (2) authorized educational leave of absence or sabbatical leave, or (3) military leave. This coverage shall continue until expiration of authorized leave and return to active service, but not to exceed 24 months for leaves under item (1) or (2). This 24-month limitation and the requirement of returning to active service shall not apply to persons receiving ordinary or accidental disability benefits or retirement benefits through the appropriate State retirement system or benefits under the Workers' Compensation or Occupational Disease Act.

(c-1) Notwithstanding any other provision of law, a State benefit recipient electing to participate in the program of health benefits shall be required to pay the entire premium of the coverage that has been elected, including the entire premium of any coverage elected for eligible dependents of the State benefit recipient.

(d) The basic group life insurance coverage shall continue, with full State contribution, where such person is (1) absent from active service by reason of disability arising from any cause other than self-inflicted, (2) on authorized educational leave of absence or sabbatical leave, or (3) on military leave.

(e) Where the person is in non-pay status for a period in excess of 30 days or on leave of absence, other than by reason of disability, educational or sabbatical leave, or military leave, such person may continue coverage only by making personal payment equal to the amount normally contributed by the State on such person's behalf. Such payments and coverage may be continued: (1) until such time as the person returns to a status eligible for coverage at State expense, but not to exceed 24 months or (2) until such person's employment or annuitant status with the State is terminated (exclusive of any additional service imposed pursuant to law).

(f) The Department shall establish by rule the extent to which other employee benefits will continue for persons in non-pay status or who are not in active service.

(g) The State shall not pay the cost of the basic non-contributory group life insurance, program of health benefits and other employee benefits for members who are survivors as defined by paragraphs (1) and (2) of subsection (q) of Section 3 of this Act. The costs of benefits for these survivors shall be paid by the survivors or by the University of Illinois Cooperative Extension Service, or any combination thereof. However, the State shall pay the amount of the reduction in the cost of participation, if any, resulting from the amendment to subsection (a) made by this amendatory Act of the 91st General Assembly.

(h) Those persons occupying positions with any department

as a result of emergency appointments pursuant to Section 8b.8 of the Personnel Code who are not considered employees under this Act shall be given the option of participating in the programs of group life insurance, health benefits and other employee benefits. Such persons electing coverage may participate only by making payment equal to the amount normally contributed by the State for similarly situated employees. Such amounts shall be determined by the Director. Such payments and coverage may be continued until such time as the person becomes an employee pursuant to this Act or such person's appointment is terminated.

(i) Any unit of local government within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a unit of local government must agree to enroll all of its employees, who may select coverage under either the State group health benefits plan or a health maintenance organization that has contracted with the State to be available as a health care provider for employees as defined in this Act. A unit of local government must remit the entire cost of providing coverage under the State group health benefits plan or, for coverage under a health maintenance organization, an amount determined by the Director based on an analysis of the sex, age, geographic location, or other relevant demographic variables for its employees, except that the unit of local government

shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the unit of local government attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 50% of the employees are enrolled and the unit of local government remits the entire cost of providing coverage to those employees, except that a participating school district must have enrolled at least 50% of its full-time employees who have not waived coverage under the district's group health plan by participating in a component of the district's cafeteria plan. A participating school district is not required to enroll a full-time employee who has waived coverage under the district's health plan, provided that an appropriate official from the participating school district attests that the full-time employee has waived coverage by participating in a component of the district's cafeteria plan. For the purposes of this subsection, "participating school district" includes a unit of local government whose primary purpose is education as defined by the Department's rules.

Employees of a participating unit of local government who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A

participating unit of local government may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the unit of local government, its employees, or some combination of the two as determined by the unit of local government. The unit of local government shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine monthly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages, or contributed by the State for basic insurance coverages on behalf of its employees, adjusted for differences between State employees and employees of the local government in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the unit of local government and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the unit of local government.

In the case of coverage of local government employees under a health maintenance organization, the Director shall annually

determine for each participating unit of local government the maximum monthly amount the unit may contribute toward that coverage, based on an analysis of (i) the age, sex, geographic location, and other relevant demographic variables of the unit's employees and (ii) the cost to cover those employees under the State group health benefits plan. The Director may similarly determine the maximum monthly amount each unit of local government may contribute toward coverage of its employees' dependents under a health maintenance organization.

Monthly payments by the unit of local government or its employees for group health benefits plan or health maintenance organization coverage shall be deposited in the Local Government Health Insurance Reserve Fund.

The Local Government Health Insurance Reserve Fund is hereby created as a nonappropriated trust fund to be held outside the State Treasury, with the State Treasurer as custodian. The Local Government Health Insurance Reserve Fund shall be a continuing fund not subject to fiscal year limitations. The Local Government Health Insurance Reserve Fund is not subject to administrative charges or charge-backs, including but not limited to those authorized under Section 8h of the State Finance Act. All revenues arising from the administration of the health benefits program established under this Section shall be deposited into the Local Government Health Insurance Reserve Fund. Any interest earned on moneys in the Local Government Health Insurance Reserve Fund shall be

deposited into the Fund. All expenditures from this Fund shall be used for payments for health care benefits for local government and rehabilitation facility employees, annuitants, and dependents, and to reimburse the Department or its administrative service organization for all expenses incurred in the administration of benefits. No other State funds may be used for these purposes.

A local government employer's participation or desire to participate in a program created under this subsection shall not limit that employer's duty to bargain with the representative of any collective bargaining unit of its employees.

(j) Any rehabilitation facility within the State of Illinois may apply to the Director to have its employees, annuitants, and their eligible dependents provided group health coverage under this Act on a non-insured basis. To participate, a rehabilitation facility must agree to enroll all of its employees and remit the entire cost of providing such coverage for its employees, except that the rehabilitation facility shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the rehabilitation facility attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 50% of the employees are enrolled and the

rehabilitation facility remits the entire cost of providing coverage to those employees. Employees of a participating rehabilitation facility who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A participating rehabilitation facility may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the rehabilitation facility, its employees, or some combination of the 2 as determined by the rehabilitation facility. The rehabilitation facility shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine quarterly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the rehabilitation facility in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the rehabilitation facility and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the rehabilitation facility.

Monthly payments by the rehabilitation facility or its employees for group health benefits shall be deposited in the Local Government Health Insurance Reserve Fund.

(k) Any domestic violence shelter or service within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a domestic violence shelter or service must agree to enroll all of its employees and pay the entire cost of providing such coverage for its employees. The domestic violence shelter shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the domestic violence shelter attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan and (2) at least 50% of the employees are enrolled and the domestic violence shelter remits the entire cost of providing coverage to those employees. Employees of a participating domestic violence shelter who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, or special circumstance as defined by the Director or during the

annual Benefit Choice Period. A participating domestic violence shelter may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with employees, or some combination of the 2 as determined by the domestic violence shelter or service. The domestic violence shelter or service shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the domestic violence shelter or service in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the domestic violence shelter or service and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the domestic violence shelter or service.

Monthly payments by the domestic violence shelter or service or its employees for group health insurance shall be

deposited in the Local Government Health Insurance Reserve Fund.

(l) A public community college or entity organized pursuant to the Public Community College Act may apply to the Director initially to have only annuitants not covered prior to July 1, 1992 by the district's health plan provided health coverage under this Act on a non-insured basis. The community college must execute a 2-year contract to participate in the Local Government Health Plan. Any annuitant may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

The Director shall annually determine monthly rates of payment subject to the following constraints: for those community colleges with annuitants only enrolled, first year rates shall be equal to the average cost to cover claims for a State member adjusted for demographics, Medicare participation, and other factors; and in the second year, a further adjustment of rates shall be made to reflect the actual first year's claims experience of the covered annuitants.

(l-5) The provisions of subsection (l) become inoperative on July 1, 1999.

(m) The Director shall adopt any rules deemed necessary for implementation of this amendatory Act of 1989 (Public Act 86-978).

(n) Any child advocacy center within the State of Illinois

may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a child advocacy center must agree to enroll all of its employees and pay the entire cost of providing coverage for its employees. The child advocacy center shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the child advocacy center attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan and (2) at least 50% of the employees are enrolled and the child advocacy center remits the entire cost of providing coverage to those employees. Employees of a participating child advocacy center who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, or special circumstance as defined by the Director or during the annual Benefit Choice Period. A participating child advocacy center may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the child advocacy center, its employees, or some combination of the 2 as determined by the child advocacy center. The child advocacy center shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment,

subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the child advocacy center in age, sex, geographic location, or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the child advocacy center and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the child advocacy center.

Monthly payments by the child advocacy center or its employees for group health insurance shall be deposited into the Local Government Health Insurance Reserve Fund.

(Source: P.A. 97-695, eff. 7-1-12; 98-488, eff. 8-16-13.)