AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Section 356z.18 as follows:

(215 ILCS 5/356z.18)

Sec. 356z.18. Prosthetic and customized orthotic devices.

(a) For the purposes of this Section:

"Customized orthotic device" means a supportive device for the body or a part of the body, the head, neck, or extremities, and includes the replacement or repair of the device based on the patient's physical condition as medically necessary, excluding foot orthotics defined as an in-shoe device designed to support the structural components of the foot during weight-bearing activities.

"Licensed provider" means a prosthetist, orthotist, or pedorthist licensed to practice in this State.

"Prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg and includes accessories essential to the effective use of the device and the replacement or repair of the device based on the patient's physical condition as medically necessary.

(b) This amendatory Act of the 96th General Assembly shall

provide benefits to any person covered thereunder for expenses incurred in obtaining a prosthetic or custom orthotic device from any Illinois licensed prosthetist, licensed orthotist, or licensed pedorthist as required under the Orthotics, Prosthetics, and Pedorthics Practice Act.

(c) A group or individual major medical policy of accident or health insurance or managed care plan or medical, health, or hospital service corporation contract that provides coverage for prosthetic or custom orthotic care and is amended, delivered, issued, or renewed 6 months after the effective date of this amendatory Act of the 96th General Assembly must provide coverage for prosthetic and orthotic devices in accordance with this subsection (c). The coverage required under this Section shall be subject to the other general exclusions, limitations, and financial requirements of the policy, including coordination of benefits, participating provider requirements, utilization review of health care services, including review of medical necessity, case management, and experimental and investigational treatments, and other managed care provisions under terms and conditions that are no less favorable than the terms and conditions that apply to substantially all medical and surgical benefits provided under the plan or coverage.

(d) With respect to an enrollee at any age, in addition to coverage of a prosthetic or custom orthotic device required by this Section, benefits shall be provided for a prosthetic or

custom orthotic device determined by the enrollee's provider to be the most appropriate model that is medically necessary for the enrollee to perform physical activities, as applicable, such as running, biking, swimming, and lifting weights, and to maximize the enrollee's whole body health and strengthen the lower and upper limb function.

(e) The requirements of this Section do not constitute an addition to this State's essential health benefits that requires defrayal of costs by this State pursuant to 42 U.S.C. 18031(d)(3)(B).

(f) ~~(d)~~ The policy or plan or contract may require prior authorization for the prosthetic or orthotic devices in the same manner that prior authorization is required for any other covered benefit.

(g) ~~(e)~~ Repairs and replacements of prosthetic and orthotic devices are also covered, subject to the co-payments and deductibles, unless necessitated by misuse or loss.

(h) ~~(f)~~ A policy or plan or contract may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this Section shall be covered benefits only if the prosthetic or orthotic devices are provided by a licensed provider employed by a provider service who contracts with or is designated by the carrier, to the extent that the carrier provides in-network and out-of-network service, the coverage for the prosthetic or orthotic device shall be offered no less extensively.

(i) ~~(g)~~ The policy or plan or contract shall also meet adequacy requirements as established by the Health Care Reimbursement Reform Act of 1985 of the Illinois Insurance Code.

(j) ~~(h)~~ This Section shall not apply to accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation insurance, or automobile medical payment insurance.

(Source: P.A. 96-833, eff. 6-1-10.)

Section 99. Effective date. This Act takes effect January 1, 2025.