Sen. Laura Fine

Filed: 5/20/2024

AMENDMENT TO HOUSE BILL 2499

AMENDMENT NO. _____. Amend House Bill 2499, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 121-2.05, 356z.18, 367.3, 367a, and 368f and by adding Section 352c as follows:

(215 ILCS 5/121-2.05) (from Ch. 73, par. 733-2.05)

Sec. 121-2.05. Group insurance policies issued and delivered in other State-Transactions in this State. With the exception of insurance transactions authorized under Sections 230.2 or 367.3 of this Code or transactions described under Section 352c, transactions in this State involving group legal, group life and group accident and health or blanket accident and health insurance or group annuities where the master policy of such groups was lawfully issued and delivered

in, and under the laws of, a State in which the insurer was authorized to do an insurance business, to a group properly established pursuant to law or regulation, and where the policyholder is domiciled or otherwise has a bona fide situs.
(Source: P.A. 86-753.)

(215 ILCS 5/352c new)

Sec. 352c. Short-term, limited-duration insurance prohibited.

(a) In this Section:

"Excepted benefits" has the meaning given to that term in 42 U.S.C. 300gg-91 and implementing regulations. "Excepted benefits" includes individual, group, or blanket coverage.

"Short-term, limited-duration insurance" means any type of accident and health insurance offered or provided within this State pursuant to a group or individual policy or individual certificate by a company, regardless of the situs state of the delivery of the policy, that has an expiration date specified in the contract that is fewer than 365 days after the original effective date. Regardless of the duration of coverage, "short-term, limited-duration insurance" does not include excepted benefits or any student health insurance coverage.

(b) On and after January 1, 2025, no company shall issue, deliver, amend, or renew short-term, limited-duration insurance to any natural or legal person that is a resident or domiciled in this State.

(215 ILCS 5/356z.18)

(Text of Section before amendment by P.A. 103-512)

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) 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.

(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.

(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.

(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.

(h) This Section shall not apply to accident only, specified disease, short-term travel ~~hospital or medical~~, hospital confinement indemnity or other fixed 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.)

(Text of Section after amendment by P.A. 103-512)

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) 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) 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) 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) 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) This Section shall not apply to accident only, specified disease, short-term travel ~~hospital or medical~~, hospital confinement indemnity or other fixed 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. 103-512, eff. 1-1-25.)

(215 ILCS 5/367.3) (from Ch. 73, par. 979.3)

Sec. 367.3. Group accident and health insurance; discretionary groups.

(a) No group health insurance offered to a resident of this State under a policy issued to a group, other than one specifically described in Section 367(1), shall be delivered or issued for delivery in this State unless the Director determines that:

(1) the issuance of the policy is not contrary to the public interest;

(2) the issuance of the policy will result in economies of acquisition and administration; and

(3) the benefits under the policy are reasonable in relation to the premium charged.

(b) No such group health insurance may be offered in this State under a policy issued in another state unless this State or the state in which the group policy is issued has made a determination that the requirements of subsection (a) have been met.

Where insurance is to be offered in this State under a policy described in this subsection, the insurer shall file for informational review purposes:

(1) a copy of the group master contract;

(2) a copy of the statute authorizing the issuance of the group policy in the state of situs, which statute has

the same or similar requirements as this State, or in the absence of such statute, a certification by an officer of the company that the policy meets the Illinois minimum standards required for individual accident and health policies under authority of Section 401 of this Code, as now or hereafter amended, as promulgated by rule at 50 Illinois Administrative Code, Ch. I, Sec. 2007, et seq., as now or hereafter amended, or by a successor rule;

(3) evidence of approval by the state of situs of the group master policy; and

(4) copies of all supportive material furnished to the state of situs to satisfy the criteria for approval.

(c) The Director may, at any time after receipt of the information required under subsection (b) and after finding that the standards of subsection (a) have not been met, order the insurer to cease the issuance or marketing of that coverage in this State.

(d) Notwithstanding subsections (a) and (b), group ~~Group~~ accident and health insurance subject to the provisions of this Section is also subject to the provisions of Sections 352c and ~~Section~~ 367i of this Code and rules thereunder.

(Source: P.A. 90-655, eff. 7-30-98.)

(215 ILCS 5/367a) (from Ch. 73, par. 979a)

Sec. 367a. Blanket accident and health insurance.

(1) Blanket accident and health insurance is the ~~that~~ form

of accident and health insurance providing excepted benefits, as defined in Section 352c, that covers ~~covering~~ special groups of persons as enumerated in one of the following paragraphs (a) to (g), inclusive:

(a) Under a policy or contract issued to any carrier for hire, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such carrier.

(b) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(c) Under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers. However, student health insurance coverage, as defined in 45 CFR 147.145, shall remain subject to the standards and requirements for individual health insurance coverage except where inconsistent with that regulation. An issuer providing student health insurance coverage or a policy or contract covering students for limited-scope dental or vision under 45 CFR 148.220 shall require an individual application or enrollment form and shall furnish each insured individual a certificate, which shall have been approved by the Director under Section 355.

(d) Under a policy or contract issued in the name of any

volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(e) Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditors; Provided, however, that in the case of a loan which is subject to the Small Loans Act, no insurance premium or other cost shall be directly or indirectly charged or assessed against, or collected or received from the borrower.

(f) Under a policy or contract issued to a sports team or to a camp, which team or camp sponsor shall be deemed the policyholder, covering members or campers.

(g) Under a policy or contract issued to any other substantially similar group which, in the discretion of the Director, may be subject to the issuance of a blanket accident and health policy or contract.

(2) Any insurance company authorized to write accident and health insurance in this state shall have the power to issue blanket accident and health insurance. No such blanket policy may be issued or delivered in this State unless a copy of the form thereof shall have been filed in accordance with Section 355, and it contains in substance such of those provisions contained in Sections 357.1 through 357.30 as may be applicable to blanket accident and health insurance and the following provisions:

(a) A provision that the policy and the application shall

constitute the entire contract between the parties, and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(b) A provision that to the group or class thereof originally insured shall be added from time to time all new persons or individuals eligible for coverage.

(3) An individual application shall not be required from a person covered under a blanket accident or health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(4) All benefits under any blanket accident and health policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his or her estate, except that if the person insured be a minor or person under legal disability, such benefits may be made payable to his or her parent, guardian, or other person actually supporting him or her. Provided further, however, that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the

amount of insurance so paid.

(5) Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of or injury to, any such member of such group.

(Source: P.A. 83-1362.)

(215 ILCS 5/368f)

Sec. 368f. Military service member insurance reinstatement.

(a) No Illinois resident activated for military service and no spouse or dependent of the resident who becomes eligible for a federal government-sponsored health insurance program, including the TriCare program providing coverage for civilian dependents of military personnel, as a result of the activation shall be denied reinstatement into the same individual health insurance coverage with the health insurer that the resident lapsed as a result of activation or becoming covered by the federal government-sponsored health insurance program. The resident shall have the right to reinstatement in the same individual health insurance coverage without medical underwriting, subject to payment of the current premium charged to other persons of the same age and gender that are covered under the same individual health coverage. Except in the case of birth or adoption that occurs during the period of activation, reinstatement must be into the same coverage type as the resident held prior to lapsing the individual health

insurance coverage and at the same or, at the option of the resident, higher deductible level. The reinstatement rights provided under this subsection (a) are not available to a resident or dependents if the activated person is discharged from the military under other than honorable conditions.

(b) The health insurer with which the reinstatement is being requested must receive a request for reinstatement no later than 63 days following the later of (i) deactivation or (ii) loss of coverage under the federal government-sponsored health insurance program. The health insurer may request proof of loss of coverage and the timing of the loss of coverage of the government-sponsored coverage in order to determine eligibility for reinstatement into the individual coverage. The effective date of the reinstatement of individual health coverage shall be the first of the month following receipt of the notice requesting reinstatement.

(c) All insurers must provide written notice to the policyholder of individual health coverage of the rights described in subsection (a) of this Section. In lieu of the inclusion of the notice in the individual health insurance policy, an insurance company may satisfy the notification requirement by providing a single written notice:

(1) in conjunction with the enrollment process for a policyholder initially enrolling in the individual coverage on or after the effective date of this amendatory Act of the 94th General Assembly; or

(2) by mailing written notice to policyholders whose coverage was effective prior to the effective date of this amendatory Act of the 94th General Assembly no later than 90 days following the effective date of this amendatory Act of the 94th General Assembly.

(d) The provisions of subsection (a) of this Section do not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity or other fixed indemnity, long-term care, Medicare supplement, vision care, or short-term travel ~~nonrenewable health policy~~ or other limited-benefit supplemental insurance, or any coverage issued as a supplement to any liability insurance, workers' compensation or similar insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket, or individual basis.

(e) Nothing in this Section shall require an insurer to reinstate the resident if the insurer requires residency in an enrollment area and those residency requirements are not met after deactivation or loss of coverage under the government-sponsored health insurance program.

(f) All terms, conditions, and limitations of the individual coverage into which reinstatement is made apply equally to all insureds enrolled in the coverage.

(g) The Secretary may adopt rules as may be necessary to

carry out the provisions of this Section.

(Source: P.A. 94-1037, eff. 7-20-06.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67, 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2,

XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

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

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

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

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not

apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its

enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or

enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

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

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

Section 15. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

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

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c, 355.2, 355.3, 355b, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 364.3, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. Nothing in this Section shall require a limited health care plan to cover any service that is not a limited health service. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

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

(2) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a domestic company under Article VIII 1/2 of the Illinois Insurance Code.

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;

102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; revised 8-29-23.)

(215 ILCS 190/Act rep.)

Section 20. The Short-Term, Limited-Duration Health Insurance Coverage Act is repealed.

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

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