HB3800

LRB104 09780 BAB 19846 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB3800

Introduced 2/18/2025, by Rep. Bob Morgan

SYNOPSIS AS INTRODUCED:

See Index

Amends the Burn Victims Relief Act. Dissolves the George Bailey Memorial Fund on June 30, 2025, or as soon thereafter as practical, and assigns any future deposits due to that Fund to the General Revenue Fund. Amends the Illinois Insurance Code. Requires every company licensed to do business in this State that is transacting the kind or kinds of business under Class 1, 2, or 3, as defined in the Code, to establish a customer affairs and information department to respond to policyholder inquiries and complaints. In provisions concerning kinds of agreements requiring approval, provides that the Director of Insurance has the right to request additional filing review and approval of all contracts that contribute to the statutory threshold trigger. Removes provisions concerning a working group related to the treatment and coverage of mental, emotional, nervous, or substance use disorders. Makes other changes. Amends the Dental Care Patient Protection Act. Makes changes concerning preemption of provisions. Amends the Health Maintenance Organization Act. Provides that health maintenance organizations are subject to provisions of the Illinois Insurance Code requiring coverage for certain at-home pregnancy tests and certain medically necessary treatments to address a major injury to the jaw. Amends the Network Adequacy and Transparency Act to make technical and combining changes to conform the changes made by Public Act 103-777 and 103-650. Amends the Limited Health Service Organization Act to make conforming changes. Amends the Criminal Code of 2012. Changes the definition of "insurance company". Effective immediately, except that certain changes to the Illinois Insurance Code are effective January 1, 2026 and certain other changes to the Illinois Insurance Code are effective 60 days after becoming law.

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A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Burn Victims Relief Act is amended by
5 changing Section 10 as follows:

6 (20 ILCS 1410/10)
7 Sec. 10. Payments to the George Bailey Memorial Fund. The
8 George Bailey Memorial Fund is created as a special fund in the
9 State treasury. Funds received under Section 16-104d of the
10 Illinois Vehicle Code shall be repaid in full to the Fire Truck
11 Revolving Loan Fund, without the deduction of the 20%
12 administrative fee authorized in subsection (b) of Section 5,
13 upon receipt by the George Bailey Memorial Fund from the
14 person or his or her estate, trust, or heirs of any moneys from
15 a settlement for the injury that is the proximate cause of the
16 person's disability under this Act or moneys received from
17 Social Security disability benefits. Moneys in the George
18 Bailey Memorial Fund may only be used for the purposes set
19 forth in this Act. <u>On June 30, 2025, or as soon thereafter as</u>
20 <u>practical, the State Comptroller shall direct the State</u>
21 <u>Treasurer to transfer the remaining balance from the George</u>
22 <u>Bailey Memorial Fund into the General Revenue Fund. Upon</u>
23 <u>completion of the transfer, the George Bailey Memorial Fund is</u>

1 dissolved, and any future deposits due to that Fund and any
2 outstanding obligations or liabilities of that Fund shall pass
3 to the General Revenue Fund.
4 (Source: P.A. 99-455, eff. 1-1-16; 100-987, eff. 7-1-19.)

5 Section 10. The Illinois Insurance Code is amended by
6 changing Sections 121-2.08, 143d, 174, 194, 356z.73, 368d,
7 370c.1, and 1563 and by renumbering and changing Section
8 356z.71 (as amended by Public Act 103-700) as follows:

9 (215 ILCS 5/121-2.08) (from Ch. 73, par. 733-2.08)
10 Sec. 121-2.08. Transactions in this State involving
11 contracts of insurance independently procured directly from an
12 unauthorized insurer by industrial insureds.
13 (a) As used in this Section:
14 "Exempt commercial purchaser" means exempt commercial
15 purchaser as the term is defined in subsection (1) of Section
16 445 of this Code.
17 "Home state" means home state as the term is defined in
18 subsection (1) of Section 445 of this Code.
19 "Industrial insured" means an insured:
20 (i) that procures the insurance of any risk or risks
21 of the kinds specified in Classes 2 and 3 of Section 4 of
22 this Code by use of the services of a full-time employee
23 who is a qualified risk manager or the services of a
24 regularly and continuously retained consultant who is a

1 qualified risk manager;
2 (ii) that procures the insurance ~~directly from an~~
3 ~~unauthorized insurer~~ without the services of an
4 intermediary insurance producer; and
5 (iii) that is an exempt commercial purchaser whose
6 home state is Illinois.
7 "Insurance producer" means insurance producer as the term
8 is defined in Section 500-10 of this Code.
9 "Qualified risk manager" means qualified risk manager as
10 the term is defined in subsection (1) of Section 445 of this
11 Code.
12 "Safety-Net Hospital" means an Illinois hospital that
13 qualifies as a Safety-Net Hospital under Section 5-5e.1 of the
14 Illinois Public Aid Code.
15 "Unauthorized insurer" means unauthorized insurer as the
16 term is defined in subsection (1) of Section 445 of this Code.
17 (b) For contracts of insurance effective January 1, 2015
18 or later, within 90 days after the effective date of each
19 contract of insurance issued under this Section, the insured
20 shall file a report with the Director by submitting the report
21 to the Surplus Line Association of Illinois in writing or in a
22 computer readable format and provide information as designated
23 by the Surplus Line Association of Illinois. The information
24 in the report shall be substantially similar to that required
25 for surplus line submissions as described in subsection (5) of
26 Section 445 of this Code. Where applicable, the report shall

1 satisfy, with respect to the subject insurance, the reporting
2 requirement of Section 12 of the Fire Investigation Act.
3 (c) For contracts of insurance effective January 1, 2015
4 through December 31, 2017, within 30 days after filing the
5 report, the insured shall pay to the Director for the use and
6 benefit of the State a sum equal to the gross premium of the
7 contract of insurance multiplied by the surplus line tax rate,
8 as described in paragraph (3) of subsection (a) of Section 445
9 of this Code, and shall pay the fire marshal tax that would
10 otherwise be due annually in March for insurance subject to
11 tax under Section 12 of the Fire Investigation Act. For
12 contracts of insurance effective January 1, 2018 or later,
13 within 30 days after filing the report, the insured shall pay
14 to the Director for the use and benefit of the State a sum
15 equal to 0.5% of the gross premium of the contract of
16 insurance, and shall pay the fire marshal tax that would
17 otherwise be due annually in March for insurance subject to
18 tax under Section 12 of the Fire Investigation Act. For
19 contracts of insurance effective January 1, 2015 or later,
20 within 30 days after filing the report, the insured shall pay
21 to the Surplus Line Association of Illinois a countersigning
22 fee that shall be assessed at the same rate charged to members
23 pursuant to subsection (4) of Section 445.1 of this Code.
24 (d) For contracts of insurance effective January 1, 2015
25 or later, the insured shall withhold the amount of the taxes
26 and countersignature fee from the amount of premium charged by

1 and otherwise payable to the insurer for the insurance. If the
2 insured fails to withhold the tax and countersignature fee
3 from the premium, then the insured shall be liable for the
4 amounts thereof and shall pay the amounts as prescribed in
5 subsection (c) of this Section.

6 (e) Contracts of insurance with an industrial insured that
7 qualifies as a Safety-Net Hospital are not subject to
8 subsections (b) through (d) of this Section.

9 (Source: P.A. 100-535, eff. 9-22-17; 100-1118, eff. 11-27-18.)

10 (215 ILCS 5/143d) (from Ch. 73, par. 755d)

11 Sec. 143d. Customer affairs and information department.

12 (a) Every company licensed to <u>do business in this State</u>
13 <u>that is transacting the kind or kinds of business under Class</u>
14 <u>1, 2, or 3, of Section 4 of this Code</u> ~~issue policies of~~
15 ~~insurance as defined in subsections (a) and (b) of Section~~
16 ~~143.13~~ shall establish a customer affairs and information
17 department to respond to policyholder inquiries and
18 complaints. The department shall be staffed by an employee or
19 employees generally knowledgeable in the affairs and
20 operations of the company. The department shall be located in
21 either the home, regional, or branch office of the company and
22 must, during regular business hours, either maintain a toll
23 free telephone number or permit policyholders to call a
24 designated telephone number at the company's expense. The
25 telephone numbers shall be made available to policyholders in

1 accordance with Section 143c ~~143(c)~~.

2 (b) The customer affairs and information department shall
3 provide information and services that may reasonably be
4 requested by policyholders who are residents of this State and
5 must respond promptly to complaints made by policyholder.
6 Companies must provide a written response to written inquiries
7 and complaints within 21 days of receipt.

8 (c) Records of the customer affairs and information
9 department shall be maintained in compliance with Department
10 of Insurance regulations.

11 (Source: P.A. 86-1407.)

12 (215 ILCS 5/174) (from Ch. 73, par. 786)

13 Sec. 174. Kinds of agreements requiring approval.

14 (1) The following kinds of reinsurance agreements shall
15 not be entered into by any domestic company unless such
16 agreements are approved in writing by the Director:

17 (a) Agreements of reinsurance of any such company
18 transacting the kind or kinds of business enumerated in
19 Class 1 of Section 4, or as a Fraternal Benefit Society
20 under Article XVII, a Mutual Benefit Association under
21 Article XVIII, a Burial Society under Article XIX or an
22 Assessment Accident and Assessment Accident and Health
23 Company under Article XXI, cedes previously issued and
24 outstanding risks to any company, or cedes any risks to a
25 company not authorized to transact business in this State,

1 or assumes any outstanding risks on which the aggregate
2 reserves and claim liabilities exceed 20% ~~20 percent~~ of
3 the aggregate reserves and claim liabilities of the
4 assuming company, as reported in the preceding annual
5 statement, for the business of either life or accident and
6 health insurance.
7 (b) Any agreement or agreements of reinsurance whereby
8 any company transacting the kind or kinds of business
9 enumerated in either Class 2 or Class 3 of Section 4 cedes
10 to any company or companies at one time, or during a period
11 of six consecutive months more than 20% ~~twenty per centum~~
12 of the total amount of its net ~~previously retained~~
13 unearned premium reserve liability. The Director has the
14 right to request additional filing review and approval of
15 all contracts that contribute to the statutory threshold
16 trigger. As used in this Section, "net unearned premium
17 reserve liability" means a liability associated with
18 existing or in-force business that is not ceded to any
19 reinsurer before the effective date of the proposed
20 reinsurance contract.
21 (c) (Blank).
22 (2) Requests for approval shall be filed at least 30
23 working days prior to the stated effective date of the
24 agreement. An agreement which is not disapproved by the
25 Director within 30 working ~~thirty~~ days after its complete
26 submission shall be deemed approved.

1 (Source: P.A. 98-969, eff. 1-1-15.)

2 (215 ILCS 5/194) (from Ch. 73, par. 806)
3 Sec. 194. Rights and liabilities of creditors fixed upon
4 liquidation.
5 (a) The rights and liabilities of the company and of its
6 creditors, policyholders, stockholders or members and all
7 other persons interested in its assets, except persons
8 entitled to file contingent claims, shall be fixed as of the
9 date of the entry of the Order directing liquidation or
10 rehabilitation unless otherwise provided by Order of the
11 Court. The rights of claimants entitled to file contingent
12 claims or to have their claims estimated shall be determined
13 as provided in Section 209.
14 (b) The Director may, within 2 years after the entry of an
15 order for rehabilitation or liquidation or within such further
16 time as applicable law permits, institute an action, claim,
17 suit, or proceeding upon any cause of action against which the
18 period of limitation fixed by applicable law has not expired
19 at the time of filing of the complaint upon which the order is
20 entered.
21 (c) The time between the filing of a complaint for
22 conservation, rehabilitation, or liquidation against the
23 company and the denial of the complaint shall not be
24 considered to be a part of the time within which any action may
25 be commenced against the company. Any action against the

1 company that might have been commenced when the complaint was
2 filed may be commenced for at least 180 days after the
3 complaint is denied.

4 (d) Notwithstanding subsection (a) of this Section,
5 policies of life, disability income, long-term care, health
6 insurance or annuities covered by a guaranty association, or
7 portions of such policies covered by one or more guaranty
8 associations under applicable law shall continue in force,
9 subject to the terms of the policy (including any terms
10 restructured pursuant to a court-approved rehabilitation plan)
11 to the extent necessary to permit the guaranty associations to
12 discharge their statutory obligations. Policies of life,
13 disability income, long-term care, health insurance or
14 annuities, or portions of such policies not covered by one or
15 more guaranty associations shall terminate as provided under
16 subsection (a) of this Section and paragraph (6) of Section
17 193 of this Article, except to the extent the Director
18 proposes and the court approves the use of property of the
19 liquidation estate for the purpose of either (1) continuing
20 the contracts or coverage by transferring them to an assuming
21 reinsurer, or (2) distributing dividends under Section 210 of
22 this Article. Claims incurred during the extension of coverage
23 provided for in this Article shall be classified at priority
24 level (d) under paragraph (1) of Section 205 of this Article.

25 (Source: P.A. 88-297; 89-206, eff. 7-21-95.)

1 (215 ILCS 5/356z.73)
2 Sec. 356z.73 ~~356z.71~~. Insurance coverage for dependent
3 parents.
4 (a) A group or individual policy of accident and health
5 insurance issued, amended, delivered, or renewed on or after
6 January 1, 2026 that provides dependent coverage shall make
7 that dependent coverage available to the parent or stepparent
8 of the insured if the parent or stepparent meets the
9 definition of a qualifying relative under 26 U.S.C. 152(d) and
10 lives or resides within the accident and health insurance
11 policy's service area.
12 (b) This Section does not apply to specialized health care
13 service plans, Medicare supplement insurance, hospital-only
14 policies, accident-only policies, or specified disease
15 insurance policies that reimburse for hospital, medical, or
16 surgical expenses.
17 (Source: P.A. 103-700, eff. 1-1-25; revised 12-3-24.)

18 (215 ILCS 5/368d)
19 Sec. 368d. Recoupments.
20 (a) A health care professional or health care provider
21 shall be provided a remittance advice, which must include an
22 explanation of a recoupment or offset taken by an insurer,
23 health maintenance organization, independent practice
24 association, or physician hospital organization, if any. The
25 recoupment explanation shall, at a minimum, include the name

1 of the patient; the date of service; the service code or if no
2 service code is available a service description; the
3 recoupment amount; and the reason for the recoupment or
4 offset. In addition, an insurer, health maintenance
5 organization, independent practice association, or physician
6 hospital organization shall provide with the remittance
7 advice, or with any demand for recoupment or offset, a
8 telephone number or mailing address to initiate an appeal of
9 the recoupment or offset together with the deadline for
10 initiating an appeal. Such information shall be prominently
11 displayed on the remittance advice or written document
12 containing the demand for recoupment or offset. Any appeal of
13 a recoupment or offset by a health care professional or health
14 care provider must be made within 60 days after receipt of the
15 remittance advice.

16 (b) It is not a recoupment when a health care professional
17 or health care provider is paid an amount prospectively or
18 concurrently under a contract with an insurer, health
19 maintenance organization, independent practice association, or
20 physician hospital organization that requires a retrospective
21 reconciliation based upon specific conditions outlined in the
22 contract.

23 (c) No recoupment or offset may be requested or withheld
24 from future payments 12 months or more after the original
25 payment is made, except in cases in which:

26 (1) a court, government administrative agency, other

tribunal, or independent third-party arbitrator makes or has made a formal finding of fraud or material misrepresentation;

(2) an insurer is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act;

(3) the provider has already been paid in full by any other payer, third party, or workers' compensation insurer; or

(4) an insurer contracted with the Department of Healthcare and Family Services is required by the Department of Healthcare and Family Services to recoup or offset payments due to a federal Medicaid requirement.

No contract between an insurer and a health care professional or health care provider may provide for recoupments in violation of this Section. Nothing in this Section shall be construed to preclude insurers, health maintenance organizations, independent practice associations, or physician hospital organizations from resolving coordination of benefits between or among each other, including, but not limited to, resolution of workers' compensation and third-party liability cases, without recouping payment from the provider beyond the 12-month ~~18-month~~ time limit provided in this subsection (c).

(Source: P.A. 102-632, eff. 1-1-22.)

(215 ILCS 5/370c.1)

1 Sec. 370c.1. Mental, emotional, nervous, or substance use
2 disorder or condition parity.
3 (a) On and after July 23, 2021 (the effective date of
4 Public Act 102-135), every insurer that amends, delivers,
5 issues, or renews a group or individual policy of accident and
6 health insurance or a qualified health plan offered through
7 the Health Insurance Marketplace in this State providing
8 coverage for hospital or medical treatment and for the
9 treatment of mental, emotional, nervous, or substance use
10 disorders or conditions shall ensure prior to policy issuance
11 that:
12 (1) the financial requirements applicable to such
13 mental, emotional, nervous, or substance use disorder or
14 condition benefits are no more restrictive than the
15 predominant financial requirements applied to
16 substantially all hospital and medical benefits covered by
17 the policy and that there are no separate cost-sharing
18 requirements that are applicable only with respect to
19 mental, emotional, nervous, or substance use disorder or
20 condition benefits; and
21 (2) the treatment limitations applicable to such
22 mental, emotional, nervous, or substance use disorder or
23 condition benefits are no more restrictive than the
24 predominant treatment limitations applied to substantially
25 all hospital and medical benefits covered by the policy
26 and that there are no separate treatment limitations that

1 are applicable only with respect to mental, emotional,
2 nervous, or substance use disorder or condition benefits.
3 (b) The following provisions shall apply concerning
4 aggregate lifetime limits:
5 (1) In the case of a group or individual policy of
6 accident and health insurance or a qualified health plan
7 offered through the Health Insurance Marketplace amended,
8 delivered, issued, or renewed in this State on or after
9 September 9, 2015 (the effective date of Public Act
10 99-480) that provides coverage for hospital or medical
11 treatment and for the treatment of mental, emotional,
12 nervous, or substance use disorders or conditions the
13 following provisions shall apply:
14 (A) if the policy does not include an aggregate
15 lifetime limit on substantially all hospital and
16 medical benefits, then the policy may not impose any
17 aggregate lifetime limit on mental, emotional,
18 nervous, or substance use disorder or condition
19 benefits; or
20 (B) if the policy includes an aggregate lifetime
21 limit on substantially all hospital and medical
22 benefits (in this subsection referred to as the
23 "applicable lifetime limit"), then the policy shall
24 either:
25 (i) apply the applicable lifetime limit both
26 to the hospital and medical benefits to which it

1 otherwise would apply and to mental, emotional,
2 nervous, or substance use disorder or condition
3 benefits and not distinguish in the application of
4 the limit between the hospital and medical
5 benefits and mental, emotional, nervous, or
6 substance use disorder or condition benefits; or
7 (ii) not include any aggregate lifetime limit
8 on mental, emotional, nervous, or substance use
9 disorder or condition benefits that is less than
10 the applicable lifetime limit.
11 (2) In the case of a policy that is not described in
12 paragraph (1) of subsection (b) of this Section and that
13 includes no or different aggregate lifetime limits on
14 different categories of hospital and medical benefits, the
15 Director shall establish rules under which subparagraph
16 (B) of paragraph (1) of subsection (b) of this Section is
17 applied to such policy with respect to mental, emotional,
18 nervous, or substance use disorder or condition benefits
19 by substituting for the applicable lifetime limit an
20 average aggregate lifetime limit that is computed taking
21 into account the weighted average of the aggregate
22 lifetime limits applicable to such categories.
23 (c) The following provisions shall apply concerning annual
24 limits:
25 (1) In the case of a group or individual policy of
26 accident and health insurance or a qualified health plan

1 offered through the Health Insurance Marketplace amended,
2 delivered, issued, or renewed in this State on or after
3 September 9, 2015 (the effective date of Public Act
4 99-480) that provides coverage for hospital or medical
5 treatment and for the treatment of mental, emotional,
6 nervous, or substance use disorders or conditions the
7 following provisions shall apply:
8 (A) if the policy does not include an annual limit
9 on substantially all hospital and medical benefits,
10 then the policy may not impose any annual limits on
11 mental, emotional, nervous, or substance use disorder
12 or condition benefits; or
13 (B) if the policy includes an annual limit on
14 substantially all hospital and medical benefits (in
15 this subsection referred to as the "applicable annual
16 limit"), then the policy shall either:
17 (i) apply the applicable annual limit both to
18 the hospital and medical benefits to which it
19 otherwise would apply and to mental, emotional,
20 nervous, or substance use disorder or condition
21 benefits and not distinguish in the application of
22 the limit between the hospital and medical
23 benefits and mental, emotional, nervous, or
24 substance use disorder or condition benefits; or
25 (ii) not include any annual limit on mental,
26 emotional, nervous, or substance use disorder or

1 condition benefits that is less than the
2 applicable annual limit.
3 (2) In the case of a policy that is not described in
4 paragraph (1) of subsection (c) of this Section and that
5 includes no or different annual limits on different
6 categories of hospital and medical benefits, the Director
7 shall establish rules under which subparagraph (B) of
8 paragraph (1) of subsection (c) of this Section is applied
9 to such policy with respect to mental, emotional, nervous,
10 or substance use disorder or condition benefits by
11 substituting for the applicable annual limit an average
12 annual limit that is computed taking into account the
13 weighted average of the annual limits applicable to such
14 categories.
15 (d) With respect to mental, emotional, nervous, or
16 substance use disorders or conditions, an insurer shall use
17 policies and procedures for the election and placement of
18 mental, emotional, nervous, or substance use disorder or
19 condition treatment drugs on their formulary that are no less
20 favorable to the insured as those policies and procedures the
21 insurer uses for the selection and placement of drugs for
22 medical or surgical conditions and shall follow the expedited
23 coverage determination requirements for substance abuse
24 treatment drugs set forth in Section 45.2 of the Managed Care
25 Reform and Patient Rights Act.
26 (e) This Section shall be interpreted in a manner

1 consistent with all applicable federal parity regulations
2 including, but not limited to, the Paul Wellstone and Pete
3 Domenici Mental Health Parity and Addiction Equity Act of
4 2008, final regulations issued under the Paul Wellstone and
5 Pete Domenici Mental Health Parity and Addiction Equity Act of
6 2008 and final regulations applying the Paul Wellstone and
7 Pete Domenici Mental Health Parity and Addiction Equity Act of
8 2008 to Medicaid managed care organizations, the Children's
9 Health Insurance Program, and alternative benefit plans.

10 (f) The provisions of subsections (b) and (c) of this
11 Section shall not be interpreted to allow the use of lifetime
12 or annual limits otherwise prohibited by State or federal law.

13 (g) As used in this Section:

14 "Financial requirement" includes deductibles, copayments,
15 coinsurance, and out-of-pocket maximums, but does not include
16 an aggregate lifetime limit or an annual limit subject to
17 subsections (b) and (c).

18 "Mental, emotional, nervous, or substance use disorder or
19 condition" means a condition or disorder that involves a
20 mental health condition or substance use disorder that falls
21 under any of the diagnostic categories listed in the mental
22 and behavioral disorders chapter of the current edition of the
23 International Classification of Disease or that is listed in
24 the most recent version of the Diagnostic and Statistical
25 Manual of Mental Disorders.

26 "Treatment limitation" includes limits on benefits based

1 on the frequency of treatment, number of visits, days of
2 coverage, days in a waiting period, or other similar limits on
3 the scope or duration of treatment. "Treatment limitation"
4 includes both quantitative treatment limitations, which are
5 expressed numerically (such as 50 outpatient visits per year),
6 and nonquantitative treatment limitations, which otherwise
7 limit the scope or duration of treatment. A permanent
8 exclusion of all benefits for a particular condition or
9 disorder shall not be considered a treatment limitation.
10 "Nonquantitative treatment" means those limitations as
11 described under federal regulations (26 CFR 54.9812-1).
12 "Nonquantitative treatment limitations" include, but are not
13 limited to, those limitations described under federal
14 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
15 146.136.

16 (h) The Department of Insurance shall implement the
17 following education initiatives:

18 (1) By January 1, 2016, the Department shall develop a
19 plan for a Consumer Education Campaign on parity. The
20 Consumer Education Campaign shall focus its efforts
21 throughout the State and include trainings in the
22 northern, southern, and central regions of the State, as
23 defined by the Department, as well as each of the 5 managed
24 care regions of the State as identified by the Department
25 of Healthcare and Family Services. Under this Consumer
26 Education Campaign, the Department shall: (1) by January

1 1, 2017, provide at least one live training in each region
2 on parity for consumers and providers and one webinar
3 training to be posted on the Department website and (2)
4 establish a consumer hotline to assist consumers in
5 navigating the parity process by March 1, 2017. By January
6 1, 2018 the Department shall issue a report to the General
7 Assembly on the success of the Consumer Education
8 Campaign, which shall indicate whether additional training
9 is necessary or would be recommended.

10 (2) (Blank). ~~The Department, in coordination with the~~
11 ~~Department of Human Services and the Department of~~
12 ~~Healthcare and Family Services, shall convene a working~~
13 ~~group of health care insurance carriers, mental health~~
14 ~~advocacy groups, substance abuse patient advocacy groups,~~
15 ~~and mental health physician groups for the purpose of~~
16 ~~discussing issues related to the treatment and coverage of~~
17 ~~mental, emotional, nervous, or substance use disorders or~~
18 ~~conditions and compliance with parity obligations under~~
19 ~~State and federal law. Compliance shall be measured,~~
20 ~~tracked, and shared during the meetings of the working~~
21 ~~group. The working group shall meet once before January 1,~~
22 ~~2016 and shall meet semiannually thereafter. The~~
23 ~~Department shall issue an annual report to the General~~
24 ~~Assembly that includes a list of the health care insurance~~
25 ~~carriers, mental health advocacy groups, substance abuse~~
26 ~~patient advocacy groups, and mental health physician~~

1 ~~groups that participated in the working group meetings,~~
2 ~~details on the issues and topics covered, and any~~
3 ~~legislative recommendations developed by the working~~
4 ~~group.~~
5 (3) Not later than January 1 of each year, the
6 Department, in conjunction with the Department of
7 Healthcare and Family Services, shall issue a joint report
8 to the General Assembly and provide an educational
9 presentation to the General Assembly. The report and
10 presentation shall:
11 (A) Cover the methodology the Departments use to
12 check for compliance with the federal Paul Wellstone
13 and Pete Domenici Mental Health Parity and Addiction
14 Equity Act of 2008, 42 U.S.C. 18031(j), and any
15 federal regulations or guidance relating to the
16 compliance and oversight of the federal Paul Wellstone
17 and Pete Domenici Mental Health Parity and Addiction
18 Equity Act of 2008 and 42 U.S.C. 18031(j).
19 (B) Cover the methodology the Departments use to
20 check for compliance with this Section and Sections
21 356z.23 and 370c of this Code.
22 (C) Identify market conduct examinations or, in
23 the case of the Department of Healthcare and Family
24 Services, audits conducted or completed during the
25 preceding 12-month period regarding compliance with
26 parity in mental, emotional, nervous, and substance

use disorder or condition benefits under State and federal laws and summarize the results of such market conduct examinations and audits. This shall include:

(i) the number of market conduct examinations and audits initiated and completed;

(ii) the benefit classifications examined by each market conduct examination and audit;

(iii) the subject matter of each market conduct examination and audit, including quantitative and nonquantitative treatment limitations; and

(iv) a summary of the basis for the final decision rendered in each market conduct examination and audit.

Individually identifiable information shall be excluded from the reports consistent with federal privacy protections.

(D) Detail any educational or corrective actions the Departments have taken to ensure compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), this Section, and Sections 356z.23 and 370c of this Code.

(E) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as

1 the Departments find appropriate, posting the report
2 on the Departments' websites.
3 (i) The Parity Advancement Fund is created as a special
4 fund in the State treasury. Moneys from fines and penalties
5 collected from insurers for violations of this Section shall
6 be deposited into the Fund. Moneys deposited into the Fund for
7 appropriation by the General Assembly to the Department shall
8 be used for the purpose of providing financial support of the
9 Consumer Education Campaign, parity compliance advocacy, and
10 other initiatives that support parity implementation and
11 enforcement on behalf of consumers.
12 (j) (Blank).
13 (j-5) The Department of Insurance shall collect the
14 following information:
15 (1) The number of employment disability insurance
16 plans offered in this State, including, but not limited
17 to:
18 (A) individual short-term policies;
19 (B) individual long-term policies;
20 (C) group short-term policies; and
21 (D) group long-term policies.
22 (2) The number of policies referenced in paragraph (1)
23 of this subsection that limit mental health and substance
24 use disorder benefits.
25 (3) The average defined benefit period for the
26 policies referenced in paragraph (1) of this subsection,

1 both for those policies that limit and those policies that
2 have no limitation on mental health and substance use
3 disorder benefits.
4 (4) Whether the policies referenced in paragraph (1)
5 of this subsection are purchased on a voluntary or
6 non-voluntary basis.
7 (5) The identities of the individuals, entities, or a
8 combination of the 2 that assume the cost associated with
9 covering the policies referenced in paragraph (1) of this
10 subsection.
11 (6) The average defined benefit period for plans that
12 cover physical disability and mental health and substance
13 abuse without limitation, including, but not limited to:
14 (A) individual short-term policies;
15 (B) individual long-term policies;
16 (C) group short-term policies; and
17 (D) group long-term policies.
18 (7) The average premiums for disability income
19 insurance issued in this State for:
20 (A) individual short-term policies that limit
21 mental health and substance use disorder benefits;
22 (B) individual long-term policies that limit
23 mental health and substance use disorder benefits;
24 (C) group short-term policies that limit mental
25 health and substance use disorder benefits;
26 (D) group long-term policies that limit mental

health and substance use disorder benefits;

(E) individual short-term policies that include mental health and substance use disorder benefits without limitation;

(F) individual long-term policies that include mental health and substance use disorder benefits without limitation;

(G) group short-term policies that include mental health and substance use disorder benefits without limitation; and

(H) group long-term policies that include mental health and substance use disorder benefits without limitation.

The Department shall present its findings regarding information collected under this subsection (j-5) to the General Assembly no later than April 30, 2024. Information regarding a specific insurance provider's contributions to the Department's report shall be exempt from disclosure under paragraph (t) of subsection (1) of Section 7 of the Freedom of Information Act. The aggregated information gathered by the Department shall not be exempt from disclosure under paragraph (t) of subsection (1) of Section 7 of the Freedom of Information Act.

(k) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance

1 marketplace in this State providing coverage for hospital or
2 medical treatment and for the treatment of mental, emotional,
3 nervous, or substance use disorders or conditions shall submit
4 an annual report, the format and definitions for which will be
5 determined by the Department and the Department of Healthcare
6 and Family Services and posted on their respective websites,
7 starting on September 1, 2023 and annually thereafter, that
8 contains the following information separately for inpatient
9 in-network benefits, inpatient out-of-network benefits,
10 outpatient in-network benefits, outpatient out-of-network
11 benefits, emergency care benefits, and prescription drug
12 benefits in the case of accident and health insurance or
13 qualified health plans, or inpatient, outpatient, emergency
14 care, and prescription drug benefits in the case of medical
15 assistance:

16 (1) A summary of the plan's pharmacy management
17 processes for mental, emotional, nervous, or substance use
18 disorder or condition benefits compared to those for other
19 medical benefits.

20 (2) A summary of the internal processes of review for
21 experimental benefits and unproven technology for mental,
22 emotional, nervous, or substance use disorder or condition
23 benefits and those for other medical benefits.

24 (3) A summary of how the plan's policies and
25 procedures for utilization management for mental,
26 emotional, nervous, or substance use disorder or condition

1 benefits compare to those for other medical benefits.
2 (4) A description of the process used to develop or
3 select the medical necessity criteria for mental,
4 emotional, nervous, or substance use disorder or condition
5 benefits and the process used to develop or select the
6 medical necessity criteria for medical and surgical
7 benefits.
8 (5) Identification of all nonquantitative treatment
9 limitations that are applied to both mental, emotional,
10 nervous, or substance use disorder or condition benefits
11 and medical and surgical benefits within each
12 classification of benefits.
13 (6) The results of an analysis that demonstrates that
14 for the medical necessity criteria described in
15 subparagraph (A) and for each nonquantitative treatment
16 limitation identified in subparagraph (B), as written and
17 in operation, the processes, strategies, evidentiary
18 standards, or other factors used in applying the medical
19 necessity criteria and each nonquantitative treatment
20 limitation to mental, emotional, nervous, or substance use
21 disorder or condition benefits within each classification
22 of benefits are comparable to, and are applied no more
23 stringently than, the processes, strategies, evidentiary
24 standards, or other factors used in applying the medical
25 necessity criteria and each nonquantitative treatment
26 limitation to medical and surgical benefits within the

1 corresponding classification of benefits; at a minimum,
2 the results of the analysis shall:
3 (A) identify the factors used to determine that a
4 nonquantitative treatment limitation applies to a
5 benefit, including factors that were considered but
6 rejected;
7 (B) identify and define the specific evidentiary
8 standards used to define the factors and any other
9 evidence relied upon in designing each nonquantitative
10 treatment limitation;
11 (C) provide the comparative analyses, including
12 the results of the analyses, performed to determine
13 that the processes and strategies used to design each
14 nonquantitative treatment limitation, as written, for
15 mental, emotional, nervous, or substance use disorder
16 or condition benefits are comparable to, and are
17 applied no more stringently than, the processes and
18 strategies used to design each nonquantitative
19 treatment limitation, as written, for medical and
20 surgical benefits;
21 (D) provide the comparative analyses, including
22 the results of the analyses, performed to determine
23 that the processes and strategies used to apply each
24 nonquantitative treatment limitation, in operation,
25 for mental, emotional, nervous, or substance use
26 disorder or condition benefits are comparable to, and

1 applied no more stringently than, the processes or
2 strategies used to apply each nonquantitative
3 treatment limitation, in operation, for medical and
4 surgical benefits; and
5 (E) disclose the specific findings and conclusions
6 reached by the insurer that the results of the
7 analyses described in subparagraphs (C) and (D)
8 indicate that the insurer is in compliance with this
9 Section and the Mental Health Parity and Addiction
10 Equity Act of 2008 and its implementing regulations,
11 which includes 42 CFR Parts 438, 440, and 457 and 45
12 CFR 146.136 and any other related federal regulations
13 found in the Code of Federal Regulations.
14 (7) Any other information necessary to clarify data
15 provided in accordance with this Section requested by the
16 Director, including information that may be proprietary or
17 have commercial value, under the requirements of Section
18 30 of the Viatical Settlements Act of 2009.
19 (l) An insurer that amends, delivers, issues, or renews a
20 group or individual policy of accident and health insurance or
21 a qualified health plan offered through the health insurance
22 marketplace in this State providing coverage for hospital or
23 medical treatment and for the treatment of mental, emotional,
24 nervous, or substance use disorders or conditions on or after
25 January 1, 2019 (the effective date of Public Act 100-1024)
26 shall, in advance of the plan year, make available to the

1 Department or, with respect to medical assistance, the
2 Department of Healthcare and Family Services and to all plan
3 participants and beneficiaries the information required in
4 subparagraphs (C) through (E) of paragraph (6) of subsection
5 (k). For plan participants and medical assistance
6 beneficiaries, the information required in subparagraphs (C)
7 through (E) of paragraph (6) of subsection (k) shall be made
8 available on a publicly available website whose web address is
9 prominently displayed in plan and managed care organization
10 informational and marketing materials.
11 (m) In conjunction with its compliance examination program
12 conducted in accordance with the Illinois State Auditing Act,
13 the Auditor General shall undertake a review of compliance by
14 the Department and the Department of Healthcare and Family
15 Services with Section 370c and this Section. Any findings
16 resulting from the review conducted under this Section shall
17 be included in the applicable State agency's compliance
18 examination report. Each compliance examination report shall
19 be issued in accordance with Section 3-14 of the Illinois
20 State Auditing Act. A copy of each report shall also be
21 delivered to the head of the applicable State agency and
22 posted on the Auditor General's website.
23 (Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21;
24 102-813, eff. 5-13-22; 103-94, eff. 1-1-24; 103-105, eff.
25 6-27-23; 103-605, eff. 7-1-24.)

1 (215 ILCS 5/1563)
2 Sec. 1563. Fees. The fees required by this Article are as
3 follows:
4 (1) Public adjuster license fee of $250 for a person
5 who is a resident of Illinois and $500 for a person who is
6 not a resident of Illinois, payable once every 2 years.
7 (2) Business entity license fee of $250, payable once
8 every 2 years.
9 (3) Application fee of $50 for processing each request
10 to take the written examination for a public adjuster
11 license.
12 (Source: P.A. 100-863, eff. 8-14-18.)

13 Section 15. The Dental Care Patient Protection Act is
14 amended by changing Section 75 as follows:

15 (215 ILCS 109/75)
16 Sec. 75. Application of other law.
17 (a) All provisions of this Act and other applicable law
18 that are not in conflict with this Act shall apply to managed
19 care dental plans and other persons subject to this Act. To the
20 extent that any provision of this Act or rule under this Act
21 would prevent the application of any standard or requirement
22 under the Network Adequacy and Transparency Act to a plan that
23 is subject to both statutes, the Network Adequacy and
24 Transparency Act shall supersede this Act.

1 (b) Solicitation of enrollees by a managed care entity
2 granted a certificate of authority or its representatives
3 shall not be construed to violate any provision of law
4 relating to solicitation or advertising by health
5 professionals.
6 (Source: P.A. 91-355, eff. 1-1-00.)

7 Section 20. The Network Adequacy and Transparency Act is
8 amended by changing Sections 5, 10, and 25 as follows:

9 (215 ILCS 124/5)
10 (Text of Section from P.A. 102-813)
11 Sec. 5. Definitions. In this Act:
12 "Authorized representative" means a person to whom a
13 beneficiary has given express written consent to represent the
14 beneficiary; a person authorized by law to provide substituted
15 consent for a beneficiary; or the beneficiary's treating
16 provider only when the beneficiary or his or her family member
17 is unable to provide consent.
18 "Beneficiary" means an individual, an enrollee, an
19 insured, a participant, or any other person entitled to
20 reimbursement for covered expenses of or the discounting of
21 provider fees for health care services under a program in
22 which the beneficiary has an incentive to utilize the services
23 of a provider that has entered into an agreement or
24 arrangement with an insurer.

1 "Department" means the Department of Insurance.
2 "Director" means the Director of Insurance.
3 "Family caregiver" means a relative, partner, friend, or
4 neighbor who has a significant relationship with the patient
5 and administers or assists the patient with activities of
6 daily living, instrumental activities of daily living, or
7 other medical or nursing tasks for the quality and welfare of
8 that patient.
9 "Insurer" means any entity that offers individual or group
10 accident and health insurance, including, but not limited to,
11 health maintenance organizations, preferred provider
12 organizations, exclusive provider organizations, and other
13 plan structures requiring network participation, excluding the
14 medical assistance program under the Illinois Public Aid Code,
15 the State employees group health insurance program, workers
16 compensation insurance, and pharmacy benefit managers.
17 "Material change" means a significant reduction in the
18 number of providers available in a network plan, including,
19 but not limited to, a reduction of 10% or more in a specific
20 type of providers, the removal of a major health system that
21 causes a network to be significantly different from the
22 network when the beneficiary purchased the network plan, or
23 any change that would cause the network to no longer satisfy
24 the requirements of this Act or the Department's rules for
25 network adequacy and transparency.
26 "Network" means the group or groups of preferred providers

1 providing services to a network plan.
2 "Network plan" means an individual or group policy of
3 accident and health insurance that either requires a covered
4 person to use or creates incentives, including financial
5 incentives, for a covered person to use providers managed,
6 owned, under contract with, or employed by the insurer.
7 "Ongoing course of treatment" means (1) treatment for a
8 life-threatening condition, which is a disease or condition
9 for which likelihood of death is probable unless the course of
10 the disease or condition is interrupted; (2) treatment for a
11 serious acute condition, defined as a disease or condition
12 requiring complex ongoing care that the covered person is
13 currently receiving, such as chemotherapy, radiation therapy,
14 or post-operative visits; (3) a course of treatment for a
15 health condition that a treating provider attests that
16 discontinuing care by that provider would worsen the condition
17 or interfere with anticipated outcomes; or (4) the third
18 trimester of pregnancy through the post-partum period.
19 "Preferred provider" means any provider who has entered,
20 either directly or indirectly, into an agreement with an
21 employer or risk-bearing entity relating to health care
22 services that may be rendered to beneficiaries under a network
23 plan.
24 "Providers" means physicians licensed to practice medicine
25 in all its branches, other health care professionals,
26 hospitals, or other health care institutions that provide

1 health care services.
2 "Short-term, limited-duration insurance" means any type of
3 accident and health insurance offered or provided within this
4 State pursuant to a group or individual policy or individual
5 certificate by a company, regardless of the situs state of the
6 delivery of the policy, that has an expiration date specified
7 in the contract that is fewer than 365 days after the original
8 effective date. Regardless of the duration of coverage,
9 "short-term, limited-duration insurance" does not include
10 excepted benefits or any student health insurance coverage.
11 "Telehealth" has the meaning given to that term in Section
12 356z.22 of the Illinois Insurance Code.
13 "Telemedicine" has the meaning given to that term in
14 Section 49.5 of the Medical Practice Act of 1987.
15 "Tiered network" means a network that identifies and
16 groups some or all types of provider and facilities into
17 specific groups to which different provider reimbursement,
18 covered person cost-sharing or provider access requirements,
19 or any combination thereof, apply for the same services.
20 "Woman's principal health care provider" means a physician
21 licensed to practice medicine in all of its branches
22 specializing in obstetrics, gynecology, or family practice.
23 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

24 (Text of Section from P.A. 103-650)
25 Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a beneficiary has given express written consent to represent the beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an issuer.

"Department" means the Department of Insurance.

"Essential community provider" has the meaning ascribed to that term in 45 CFR 156.235.

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

"Exchange" has the meaning ascribed to that term in 45 CFR 155.20.

"Director" means the Director of Insurance.

"Family caregiver" means a relative, partner, friend, or neighbor who has a significant relationship with the patient and administers or assists the patient with activities of

1 daily living, instrumental activities of daily living, or
2 other medical or nursing tasks for the quality and welfare of
3 that patient.
4 "Group health plan" has the meaning ascribed to that term
5 in Section 5 of the Illinois Health Insurance Portability and
6 Accountability Act.
7 "Health insurance coverage" has the meaning ascribed to
8 that term in Section 5 of the Illinois Health Insurance
9 Portability and Accountability Act. "Health insurance
10 coverage" does not include any coverage or benefits under
11 Medicare or under the medical assistance program established
12 under Article V of the Illinois Public Aid Code.
13 "Issuer" means a "health insurance issuer" as defined in
14 Section 5 of the Illinois Health Insurance Portability and
15 Accountability Act.
16 "Material change" means a significant reduction in the
17 number of providers available in a network plan, including,
18 but not limited to, a reduction of 10% or more in a specific
19 type of providers within any county, the removal of a major
20 health system that causes a network to be significantly
21 different within any county from the network when the
22 beneficiary purchased the network plan, or any change that
23 would cause the network to no longer satisfy the requirements
24 of this Act or the Department's rules for network adequacy and
25 transparency.
26 "Network" means the group or groups of preferred providers

1 providing services to a network plan.
2 "Network plan" means an individual or group policy of
3 health insurance coverage that either requires a covered
4 person to use or creates incentives, including financial
5 incentives, for a covered person to use providers managed,
6 owned, under contract with, or employed by the issuer or by a
7 third party contracted to arrange, contract for, or administer
8 such provider-related incentives for the issuer.
9 "Ongoing course of treatment" means (1) treatment for a
10 life-threatening condition, which is a disease or condition
11 for which likelihood of death is probable unless the course of
12 the disease or condition is interrupted; (2) treatment for a
13 serious acute condition, defined as a disease or condition
14 requiring complex ongoing care that the covered person is
15 currently receiving, such as chemotherapy, radiation therapy,
16 post-operative visits, or a serious and complex condition as
17 defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of
18 treatment for a health condition that a treating provider
19 attests that discontinuing care by that provider would worsen
20 the condition or interfere with anticipated outcomes; (4) the
21 third trimester of pregnancy through the post-partum period;
22 (5) undergoing a course of institutional or inpatient care
23 from the provider within the meaning of 42 U.S.C.
24 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective
25 surgery from the provider, including receipt of preoperative
26 or postoperative care from such provider with respect to such

1 a surgery; (7) being determined to be terminally ill, as
2 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving
3 treatment for such illness from such provider; or (8) any
4 other treatment of a condition or disease that requires
5 repeated health care services pursuant to a plan of treatment
6 by a provider because of the potential for changes in the
7 therapeutic regimen or because of the potential for a
8 recurrence of symptoms.

9 "Preferred provider" means any provider who has entered,
10 either directly or indirectly, into an agreement with an
11 employer or risk-bearing entity relating to health care
12 services that may be rendered to beneficiaries under a network
13 plan.

14 "Providers" means physicians licensed to practice medicine
15 in all its branches, other health care professionals,
16 hospitals, or other health care institutions or facilities
17 that provide health care services.

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

1 "Stand-alone dental plan" has the meaning ascribed to that
2 term in 45 CFR 156.400.
3 "Telehealth" has the meaning given to that term in Section
4 356z.22 of the Illinois Insurance Code.
5 "Telemedicine" has the meaning given to that term in
6 Section 49.5 of the Medical Practice Act of 1987.
7 "Tiered network" means a network that identifies and
8 groups some or all types of provider and facilities into
9 specific groups to which different provider reimbursement,
10 covered person cost-sharing or provider access requirements,
11 or any combination thereof, apply for the same services.
12 "Woman's principal health care provider" means a physician
13 licensed to practice medicine in all of its branches
14 specializing in obstetrics, gynecology, or family practice.
15 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
16 103-650, eff. 1-1-25.)

17 (Text of Section from P.A. 103-718)
18 Sec. 5. Definitions. In this Act:
19 "Authorized representative" means a person to whom a
20 beneficiary has given express written consent to represent the
21 beneficiary; a person authorized by law to provide substituted
22 consent for a beneficiary; or the beneficiary's treating
23 provider only when the beneficiary or his or her family member
24 is unable to provide consent.
25 "Beneficiary" means an individual, an enrollee, an

1 insured, a participant, or any other person entitled to
2 reimbursement for covered expenses of or the discounting of
3 provider fees for health care services under a program in
4 which the beneficiary has an incentive to utilize the services
5 of a provider that has entered into an agreement or
6 arrangement with an insurer.

7 "Department" means the Department of Insurance.

8 "Director" means the Director of Insurance.

9 "Family caregiver" means a relative, partner, friend, or
10 neighbor who has a significant relationship with the patient
11 and administers or assists the patient with activities of
12 daily living, instrumental activities of daily living, or
13 other medical or nursing tasks for the quality and welfare of
14 that patient.

15 "Insurer" means any entity that offers individual or group
16 accident and health insurance, including, but not limited to,
17 health maintenance organizations, preferred provider
18 organizations, exclusive provider organizations, and other
19 plan structures requiring network participation, excluding the
20 medical assistance program under the Illinois Public Aid Code,
21 the State employees group health insurance program, workers
22 compensation insurance, and pharmacy benefit managers.

23 "Material change" means a significant reduction in the
24 number of providers available in a network plan, including,
25 but not limited to, a reduction of 10% or more in a specific
26 type of providers, the removal of a major health system that

1 causes a network to be significantly different from the
2 network when the beneficiary purchased the network plan, or
3 any change that would cause the network to no longer satisfy
4 the requirements of this Act or the Department's rules for
5 network adequacy and transparency.

6 "Network" means the group or groups of preferred providers
7 providing services to a network plan.

8 "Network plan" means an individual or group policy of
9 accident and health insurance that either requires a covered
10 person to use or creates incentives, including financial
11 incentives, for a covered person to use providers managed,
12 owned, under contract with, or employed by the insurer.

13 "Ongoing course of treatment" means (1) treatment for a
14 life-threatening condition, which is a disease or condition
15 for which likelihood of death is probable unless the course of
16 the disease or condition is interrupted; (2) treatment for a
17 serious acute condition, defined as a disease or condition
18 requiring complex ongoing care that the covered person is
19 currently receiving, such as chemotherapy, radiation therapy,
20 or post-operative visits; (3) a course of treatment for a
21 health condition that a treating provider attests that
22 discontinuing care by that provider would worsen the condition
23 or interfere with anticipated outcomes; or (4) the third
24 trimester of pregnancy through the post-partum period.

25 "Preferred provider" means any provider who has entered,
26 either directly or indirectly, into an agreement with an

1 employer or risk-bearing entity relating to health care
2 services that may be rendered to beneficiaries under a network
3 plan.

4 "Providers" means physicians licensed to practice medicine
5 in all its branches, other health care professionals,
6 hospitals, or other health care institutions that provide
7 health care services.

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

17 "Telehealth" has the meaning given to that term in Section
18 356z.22 of the Illinois Insurance Code.

19 "Telemedicine" has the meaning given to that term in
20 Section 49.5 of the Medical Practice Act of 1987.

21 "Tiered network" means a network that identifies and
22 groups some or all types of provider and facilities into
23 specific groups to which different provider reimbursement,
24 covered person cost-sharing or provider access requirements,
25 or any combination thereof, apply for the same services.

26 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;

1 103-718, eff. 7-19-24.)

2 (Text of Section from P.A. 103-777)
3 Sec. 5. Definitions. In this Act:
4 "Authorized representative" means a person to whom a
5 beneficiary has given express written consent to represent the
6 beneficiary; a person authorized by law to provide substituted
7 consent for a beneficiary; or the beneficiary's treating
8 provider only when the beneficiary or his or her family member
9 is unable to provide consent.
10 "Beneficiary" means an individual, an enrollee, an
11 insured, a participant, or any other person entitled to
12 reimbursement for covered expenses of or the discounting of
13 provider fees for health care services under a program in
14 which the beneficiary has an incentive to utilize the services
15 of a provider that has entered into an agreement or
16 arrangement with an insurer.
17 "Department" means the Department of Insurance.
18 "Director" means the Director of Insurance.
19 "Excepted benefits" has the meaning given to that term in
20 42 U.S.C. 300gg-91(c).
21 "Family caregiver" means a relative, partner, friend, or
22 neighbor who has a significant relationship with the patient
23 and administers or assists the patient with activities of
24 daily living, instrumental activities of daily living, or
25 other medical or nursing tasks for the quality and welfare of

1 that patient.

2 "Insurer" means any entity that offers individual or group
3 accident and health insurance, including, but not limited to,
4 health maintenance organizations, preferred provider
5 organizations, exclusive provider organizations, and other
6 plan structures requiring network participation, excluding the
7 medical assistance program under the Illinois Public Aid Code,
8 the State employees group health insurance program, workers
9 compensation insurance, and pharmacy benefit managers.

10 "Material change" means a significant reduction in the
11 number of providers available in a network plan, including,
12 but not limited to, a reduction of 10% or more in a specific
13 type of providers, the removal of a major health system that
14 causes a network to be significantly different from the
15 network when the beneficiary purchased the network plan, or
16 any change that would cause the network to no longer satisfy
17 the requirements of this Act or the Department's rules for
18 network adequacy and transparency.

19 "Network" means the group or groups of preferred providers
20 providing services to a network plan.

21 "Network plan" means an individual or group policy of
22 accident and health insurance that either requires a covered
23 person to use or creates incentives, including financial
24 incentives, for a covered person to use providers managed,
25 owned, under contract with, or employed by the insurer.

26 "Ongoing course of treatment" means (1) treatment for a

1 life-threatening condition, which is a disease or condition
2 for which likelihood of death is probable unless the course of
3 the disease or condition is interrupted; (2) treatment for a
4 serious acute condition, defined as a disease or condition
5 requiring complex ongoing care that the covered person is
6 currently receiving, such as chemotherapy, radiation therapy,
7 or post-operative visits; (3) a course of treatment for a
8 health condition that a treating provider attests that
9 discontinuing care by that provider would worsen the condition
10 or interfere with anticipated outcomes; or (4) the third
11 trimester of pregnancy through the post-partum period.

12 "Preferred provider" means any provider who has entered,
13 either directly or indirectly, into an agreement with an
14 employer or risk-bearing entity relating to health care
15 services that may be rendered to beneficiaries under a network
16 plan.

17 "Providers" means physicians licensed to practice medicine
18 in all its branches, other health care professionals,
19 hospitals, or other health care institutions that provide
20 health care services.

21 "Short-term, limited-duration health insurance coverage"
22 means any type of accident and health insurance offered or
23 provided within this State pursuant to a group or individual
24 policy or individual certificate by a company, regardless of
25 the situs state of the delivery of the policy, that has an
26 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. ~~has the meaning given to that term in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act.~~

"Stand-alone dental plan" has the meaning given to that term in 45 CFR 156.400.

"Telehealth" has the meaning given to that term in Section 356z.22 of the Illinois Insurance Code.

"Telemedicine" has the meaning given to that term in Section 49.5 of the Medical Practice Act of 1987.

"Tiered network" means a network that identifies and groups some or all types of provider and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22; 103-777, eff. 1-1-25.)

(215 ILCS 124/10)

(Text of Section from P.A. 103-650)

Sec. 10. Network adequacy.

1 (a) Before issuing, delivering, or renewing a network
2 plan, an issuer providing a network plan shall file a
3 description of all of the following with the Director:
4 (1) The written policies and procedures for adding
5 providers to meet patient needs based on increases in the
6 number of beneficiaries, changes in the
7 patient-to-provider ratio, changes in medical and health
8 care capabilities, and increased demand for services.
9 (2) The written policies and procedures for making
10 referrals within and outside the network.
11 (3) The written policies and procedures on how the
12 network plan will provide 24-hour, 7-day per week access
13 to network-affiliated primary care, emergency services,
14 and women's principal health care providers.
15 An issuer shall not prohibit a preferred provider from
16 discussing any specific or all treatment options with
17 beneficiaries irrespective of the insurer's position on those
18 treatment options or from advocating on behalf of
19 beneficiaries within the utilization review, grievance, or
20 appeals processes established by the issuer in accordance with
21 any rights or remedies available under applicable State or
22 federal law.
23 (b) Before issuing, delivering, or renewing a network
24 plan, an issuer must file for review a description of the
25 services to be offered through a network plan. The description
26 shall include all of the following:

1 (1) A geographic map of the area proposed to be served
2 by the plan by county service area and zip code, including
3 marked locations for preferred providers.
4 (2) As deemed necessary by the Department, the names,
5 addresses, phone numbers, and specialties of the providers
6 who have entered into preferred provider agreements under
7 the network plan.
8 (3) The number of beneficiaries anticipated to be
9 covered by the network plan.
10 (4) An Internet website and toll-free telephone number
11 for beneficiaries and prospective beneficiaries to access
12 current and accurate lists of preferred providers in each
13 plan, additional information about the plan, as well as
14 any other information required by Department rule.
15 (5) A description of how health care services to be
16 rendered under the network plan are reasonably accessible
17 and available to beneficiaries. The description shall
18 address all of the following:
19 (A) the type of health care services to be
20 provided by the network plan;
21 (B) the ratio of physicians and other providers to
22 beneficiaries, by specialty and including primary care
23 physicians and facility-based physicians when
24 applicable under the contract, necessary to meet the
25 health care needs and service demands of the currently
26 enrolled population;

1 (C) the travel and distance standards for plan
2 beneficiaries in county service areas; and
3 (D) a description of how the use of telemedicine,
4 telehealth, or mobile care services may be used to
5 partially meet the network adequacy standards, if
6 applicable.
7 (6) A provision ensuring that whenever a beneficiary
8 has made a good faith effort, as evidenced by accessing
9 the provider directory, calling the network plan, and
10 calling the provider, to utilize preferred providers for a
11 covered service and it is determined the insurer does not
12 have the appropriate preferred providers due to
13 insufficient number, type, unreasonable travel distance or
14 delay, or preferred providers refusing to provide a
15 covered service because it is contrary to the conscience
16 of the preferred providers, as protected by the Health
17 Care Right of Conscience Act, the issuer shall ensure,
18 directly or indirectly, by terms contained in the payer
19 contract, that the beneficiary will be provided the
20 covered service at no greater cost to the beneficiary than
21 if the service had been provided by a preferred provider.
22 This paragraph (6) does not apply to: (A) a beneficiary
23 who willfully chooses to access a non-preferred provider
24 for health care services available through the panel of
25 preferred providers, or (B) a beneficiary enrolled in a
26 health maintenance organization. In these circumstances,

1 the contractual requirements for non-preferred provider
2 reimbursements shall apply unless Section 356z.3a of the
3 Illinois Insurance Code requires otherwise. In no event
4 shall a beneficiary who receives care at a participating
5 health care facility be required to search for
6 participating providers under the circumstances described
7 in subsection (b) or (b-5) of Section 356z.3a of the
8 Illinois Insurance Code except under the circumstances
9 described in paragraph (2) of subsection (b-5).
10 (7) A provision that the beneficiary shall receive
11 emergency care coverage such that payment for this
12 coverage is not dependent upon whether the emergency
13 services are performed by a preferred or non-preferred
14 provider and the coverage shall be at the same benefit
15 level as if the service or treatment had been rendered by a
16 preferred provider. For purposes of this paragraph (7),
17 "the same benefit level" means that the beneficiary is
18 provided the covered service at no greater cost to the
19 beneficiary than if the service had been provided by a
20 preferred provider. This provision shall be consistent
21 with Section 356z.3a of the Illinois Insurance Code.
22 (8) A limitation that, if the plan provides that the
23 beneficiary will incur a penalty for failing to
24 pre-certify inpatient hospital treatment, the penalty may
25 not exceed $1,000 per occurrence in addition to the plan
26 cost sharing provisions.

1 (9) For a network plan to be offered through the
2 Exchange in the individual or small group market, as well
3 as any off-Exchange mirror of such a network plan,
4 evidence that the network plan includes essential
5 community providers in accordance with rules established
6 by the Exchange that will operate in this State for the
7 applicable plan year.

8 (c) The issuer shall demonstrate to the Director a minimum
9 ratio of providers to plan beneficiaries as required by the
10 Department for each network plan.

11 (1) The minimum ratio of physicians or other providers
12 to plan beneficiaries shall be established by the
13 Department in consultation with the Department of Public
14 Health based upon the guidance from the federal Centers
15 for Medicare and Medicaid Services. The Department shall
16 not establish ratios for vision or dental providers who
17 provide services under dental-specific or vision-specific
18 benefits, except to the extent provided under federal law
19 for stand-alone dental plans. The Department shall
20 consider establishing ratios for the following physicians
21 or other providers:

22 (A) Primary Care;
23 (B) Pediatrics;
24 (C) Cardiology;
25 (D) Gastroenterology;
26 (E) General Surgery;

1 (F) Neurology;
2 (G) OB/GYN;
3 (H) Oncology/Radiation;
4 (I) Ophthalmology;
5 (J) Urology;
6 (K) Behavioral Health;
7 (L) Allergy/Immunology;
8 (M) Chiropractic;
9 (N) Dermatology;
10 (O) Endocrinology;
11 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
12 (Q) Infectious Disease;
13 (R) Nephrology;
14 (S) Neurosurgery;
15 (T) Orthopedic Surgery;
16 (U) Physiatry/Rehabilitative;
17 (V) Plastic Surgery;
18 (W) Pulmonary;
19 (X) Rheumatology;
20 (Y) Anesthesiology;
21 (Z) Pain Medicine;
22 (AA) Pediatric Specialty Services;
23 (BB) Outpatient Dialysis; and
24 (CC) HIV.
25 (2) The Director shall establish a process for the
26 review of the adequacy of these standards, along with an

1 assessment of additional specialties to be included in the
2 list under this subsection (c).

3 (3) Notwithstanding any other law or rule, the minimum
4 ratio for each provider type shall be no less than any such
5 ratio established for qualified health plans in
6 Federally-Facilitated Exchanges by federal law or by the
7 federal Centers for Medicare and Medicaid Services, even
8 if the network plan is issued in the large group market or
9 is otherwise not issued through an exchange. Federal
10 standards for stand-alone dental plans shall only apply to
11 such network plans. In the absence of an applicable
12 Department rule, the federal standards shall apply for the
13 time period specified in the federal law, regulation, or
14 guidance. If the Centers for Medicare and Medicaid
15 Services establish standards that are more stringent than
16 the standards in effect under any Department rule, the
17 Department may amend its rules to conform to the more
18 stringent federal standards.

19 (d) The network plan shall demonstrate to the Director
20 maximum travel and distance standards and appointment wait
21 time standards for plan beneficiaries, which shall be
22 established by the Department in consultation with the
23 Department of Public Health based upon the guidance from the
24 federal Centers for Medicare and Medicaid Services. These
25 standards shall consist of the maximum minutes or miles to be
26 traveled by a plan beneficiary for each county type, such as

1 large counties, metro counties, or rural counties as defined
2 by Department rule.
3 The maximum travel time and distance standards must
4 include standards for each physician and other provider
5 category listed for which ratios have been established.
6 The Director shall establish a process for the review of
7 the adequacy of these standards along with an assessment of
8 additional specialties to be included in the list under this
9 subsection (d).
10 Notwithstanding any other law or Department rule, the
11 maximum travel time and distance standards and appointment
12 wait time standards shall be no greater than any such
13 standards established for qualified health plans in
14 Federally-Facilitated Exchanges by federal law or by the
15 federal Centers for Medicare and Medicaid Services, even if
16 the network plan is issued in the large group market or is
17 otherwise not issued through an exchange. Federal standards
18 for stand-alone dental plans shall only apply to such network
19 plans. In the absence of an applicable Department rule, the
20 federal standards shall apply for the time period specified in
21 the federal law, regulation, or guidance. If the Centers for
22 Medicare and Medicaid Services establish standards that are
23 more stringent than the standards in effect under any
24 Department rule, the Department may amend its rules to conform
25 to the more stringent federal standards.
26 If the federal area designations for the maximum time or

1 distance or appointment wait time standards required are
2 changed by the most recent Letter to Issuers in the
3 Federally-facilitated Marketplaces, the Department shall post
4 on its website notice of such changes and may amend its rules
5 to conform to those designations if the Director deems
6 appropriate.
7 (d-5)(1) Every issuer shall ensure that beneficiaries have
8 timely and proximate access to treatment for mental,
9 emotional, nervous, or substance use disorders or conditions
10 in accordance with the provisions of paragraph (4) of
11 subsection (a) of Section 370c of the Illinois Insurance Code.
12 Issuers shall use a comparable process, strategy, evidentiary
13 standard, and other factors in the development and application
14 of the network adequacy standards for timely and proximate
15 access to treatment for mental, emotional, nervous, or
16 substance use disorders or conditions and those for the access
17 to treatment for medical and surgical conditions. As such, the
18 network adequacy standards for timely and proximate access
19 shall equally be applied to treatment facilities and providers
20 for mental, emotional, nervous, or substance use disorders or
21 conditions and specialists providing medical or surgical
22 benefits pursuant to the parity requirements of Section 370c.1
23 of the Illinois Insurance Code and the federal Paul Wellstone
24 and Pete Domenici Mental Health Parity and Addiction Equity
25 Act of 2008. Notwithstanding the foregoing, the network
26 adequacy standards for timely and proximate access to

1 treatment for mental, emotional, nervous, or substance use
2 disorders or conditions shall, at a minimum, satisfy the
3 following requirements:
4 (A) For beneficiaries residing in the metropolitan
5 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
6 network adequacy standards for timely and proximate access
7 to treatment for mental, emotional, nervous, or substance
8 use disorders or conditions means a beneficiary shall not
9 have to travel longer than 30 minutes or 30 miles from the
10 beneficiary's residence to receive outpatient treatment
11 for mental, emotional, nervous, or substance use disorders
12 or conditions. Beneficiaries shall not be required to wait
13 longer than 10 business days between requesting an initial
14 appointment and being seen by the facility or provider of
15 mental, emotional, nervous, or substance use disorders or
16 conditions for outpatient treatment or to wait longer than
17 20 business days between requesting a repeat or follow-up
18 appointment and being seen by the facility or provider of
19 mental, emotional, nervous, or substance use disorders or
20 conditions for outpatient treatment; however, subject to
21 the protections of paragraph (3) of this subsection, a
22 network plan shall not be held responsible if the
23 beneficiary or provider voluntarily chooses to schedule an
24 appointment outside of these required time frames.
25 (B) For beneficiaries residing in Illinois counties
26 other than those counties listed in subparagraph (A) of

1 this paragraph, network adequacy standards for timely and
2 proximate access to treatment for mental, emotional,
3 nervous, or substance use disorders or conditions means a
4 beneficiary shall not have to travel longer than 60
5 minutes or 60 miles from the beneficiary's residence to
6 receive outpatient treatment for mental, emotional,
7 nervous, or substance use disorders or conditions.
8 Beneficiaries shall not be required to wait longer than 10
9 business days between requesting an initial appointment
10 and being seen by the facility or provider of mental,
11 emotional, nervous, or substance use disorders or
12 conditions for outpatient treatment or to wait longer than
13 20 business days between requesting a repeat or follow-up
14 appointment and being seen by the facility or provider of
15 mental, emotional, nervous, or substance use disorders or
16 conditions for outpatient treatment; however, subject to
17 the protections of paragraph (3) of this subsection, a
18 network plan shall not be held responsible if the
19 beneficiary or provider voluntarily chooses to schedule an
20 appointment outside of these required time frames.

21 (2) For beneficiaries residing in all Illinois counties,
22 network adequacy standards for timely and proximate access to
23 treatment for mental, emotional, nervous, or substance use
24 disorders or conditions means a beneficiary shall not have to
25 travel longer than 60 minutes or 60 miles from the
26 beneficiary's residence to receive inpatient or residential

1 treatment for mental, emotional, nervous, or substance use
2 disorders or conditions.
3 (3) If there is no in-network facility or provider
4 available for a beneficiary to receive timely and proximate
5 access to treatment for mental, emotional, nervous, or
6 substance use disorders or conditions in accordance with the
7 network adequacy standards outlined in this subsection, the
8 issuer shall provide necessary exceptions to its network to
9 ensure admission and treatment with a provider or at a
10 treatment facility in accordance with the network adequacy
11 standards in this subsection.
12 (4) If the federal Centers for Medicare and Medicaid
13 Services establishes or law requires more stringent standards
14 for qualified health plans in the Federally-Facilitated
15 Exchanges, the federal standards shall control for all network
16 plans for the time period specified in the federal law,
17 regulation, or guidance, even if the network plan is issued in
18 the large group market, is issued through a different type of
19 Exchange, or is otherwise not issued through an Exchange.
20 (e) Except for network plans solely offered as a group
21 health plan, these ratio and time and distance standards apply
22 to the lowest cost-sharing tier of any tiered network.
23 (f) The network plan may consider use of other health care
24 service delivery options, such as telemedicine or telehealth,
25 mobile clinics, and centers of excellence, or other ways of
26 delivering care to partially meet the requirements set under

this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers ~~issuers~~ who are not able to comply with the provider ratios, ~~and~~ time and distance standards, and ~~or~~ appointment wait-time ~~wait time~~ standards established under this Act or federal law may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the issuer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the issuer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

1 (h) Issuers are required to report to the Director any
2 material change to an approved network plan within 15 business
3 days after the change occurs and any change that would result
4 in failure to meet the requirements of this Act. The issuer
5 shall submit a revised version of the portions of the network
6 adequacy filing affected by the material change, as determined
7 by the Director by rule, and the issuer shall attach versions
8 with the changes indicated for each document that was revised
9 from the previous version of the filing. Upon notice from the
10 issuer, the Director shall reevaluate the network plan's
11 compliance with the network adequacy and transparency
12 standards of this Act. For every day past 15 business days that
13 the issuer fails to submit a revised network adequacy filing
14 to the Director, the Director may order a fine of $5,000 per
15 day.

16 (i) If a network plan is inadequate under this Act with
17 respect to a provider type in a county, and if the network plan
18 does not have an approved exception for that provider type in
19 that county pursuant to subsection (g), an issuer shall cover
20 out-of-network claims for covered health care services
21 received from that provider type within that county at the
22 in-network benefit level and shall retroactively adjudicate
23 and reimburse beneficiaries to achieve that objective if their
24 claims were processed at the out-of-network level contrary to
25 this subsection. Nothing in this subsection shall be construed
26 to supersede Section 356z.3a of the Illinois Insurance Code.

1 (j) If the Director determines that a network is
2 inadequate in any county and no exception has been granted
3 under subsection (g) and the issuer does not have a process in
4 place to comply with subsection (d-5), the Director may
5 prohibit the network plan from being issued or renewed within
6 that county until the Director determines that the network is
7 adequate apart from processes and exceptions described in
8 subsections (d-5) and (g). Nothing in this subsection shall be
9 construed to terminate any beneficiary's health insurance
10 coverage under a network plan before the expiration of the
11 beneficiary's policy period if the Director makes a
12 determination under this subsection after the issuance or
13 renewal of the beneficiary's policy or certificate because of
14 a material change. Policies or certificates issued or renewed
15 in violation of this subsection may subject the issuer to a
16 civil penalty of $5,000 per policy.
17 (k) For the Department to enforce any new or modified
18 federal standard before the Department adopts the standard by
19 rule, the Department must, no later than May 15 before the
20 start of the plan year, give public notice to the affected
21 health insurance issuers through a bulletin.
22 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
23 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

24 (Text of Section from P.A. 103-656)
25 Sec. 10. Network adequacy.

1 (a) An insurer providing a network plan shall file a
2 description of all of the following with the Director:
3 (1) The written policies and procedures for adding
4 providers to meet patient needs based on increases in the
5 number of beneficiaries, changes in the
6 patient-to-provider ratio, changes in medical and health
7 care capabilities, and increased demand for services.
8 (2) The written policies and procedures for making
9 referrals within and outside the network.
10 (3) The written policies and procedures on how the
11 network plan will provide 24-hour, 7-day per week access
12 to network-affiliated primary care, emergency services,
13 and women's principal health care providers.
14 An insurer shall not prohibit a preferred provider from
15 discussing any specific or all treatment options with
16 beneficiaries irrespective of the insurer's position on those
17 treatment options or from advocating on behalf of
18 beneficiaries within the utilization review, grievance, or
19 appeals processes established by the insurer in accordance
20 with any rights or remedies available under applicable State
21 or federal law.
22 (b) Insurers must file for review a description of the
23 services to be offered through a network plan. The description
24 shall include all of the following:
25 (1) A geographic map of the area proposed to be served
26 by the plan by county service area and zip code, including

1 marked locations for preferred providers.
2 (2) As deemed necessary by the Department, the names,
3 addresses, phone numbers, and specialties of the providers
4 who have entered into preferred provider agreements under
5 the network plan.
6 (3) The number of beneficiaries anticipated to be
7 covered by the network plan.
8 (4) An Internet website and toll-free telephone number
9 for beneficiaries and prospective beneficiaries to access
10 current and accurate lists of preferred providers,
11 additional information about the plan, as well as any
12 other information required by Department rule.
13 (5) A description of how health care services to be
14 rendered under the network plan are reasonably accessible
15 and available to beneficiaries. The description shall
16 address all of the following:
17 (A) the type of health care services to be
18 provided by the network plan;
19 (B) the ratio of physicians and other providers to
20 beneficiaries, by specialty and including primary care
21 physicians and facility-based physicians when
22 applicable under the contract, necessary to meet the
23 health care needs and service demands of the currently
24 enrolled population;
25 (C) the travel and distance standards for plan
26 beneficiaries in county service areas; and

1 (D) a description of how the use of telemedicine,
2 telehealth, or mobile care services may be used to
3 partially meet the network adequacy standards, if
4 applicable.
5 (6) A provision ensuring that whenever a beneficiary
6 has made a good faith effort, as evidenced by accessing
7 the provider directory, calling the network plan, and
8 calling the provider, to utilize preferred providers for a
9 covered service and it is determined the insurer does not
10 have the appropriate preferred providers due to
11 insufficient number, type, unreasonable travel distance or
12 delay, or preferred providers refusing to provide a
13 covered service because it is contrary to the conscience
14 of the preferred providers, as protected by the Health
15 Care Right of Conscience Act, the insurer shall ensure,
16 directly or indirectly, by terms contained in the payer
17 contract, that the beneficiary will be provided the
18 covered service at no greater cost to the beneficiary than
19 if the service had been provided by a preferred provider.
20 This paragraph (6) does not apply to: (A) a beneficiary
21 who willfully chooses to access a non-preferred provider
22 for health care services available through the panel of
23 preferred providers, or (B) a beneficiary enrolled in a
24 health maintenance organization. In these circumstances,
25 the contractual requirements for non-preferred provider
26 reimbursements shall apply unless Section 356z.3a of the

1 Illinois Insurance Code requires otherwise. In no event
2 shall a beneficiary who receives care at a participating
3 health care facility be required to search for
4 participating providers under the circumstances described
5 in subsection (b) or (b-5) of Section 356z.3a of the
6 Illinois Insurance Code except under the circumstances
7 described in paragraph (2) of subsection (b-5).
8 (7) A provision that the beneficiary shall receive
9 emergency care coverage such that payment for this
10 coverage is not dependent upon whether the emergency
11 services are performed by a preferred or non-preferred
12 provider and the coverage shall be at the same benefit
13 level as if the service or treatment had been rendered by a
14 preferred provider. For purposes of this paragraph (7),
15 "the same benefit level" means that the beneficiary is
16 provided the covered service at no greater cost to the
17 beneficiary than if the service had been provided by a
18 preferred provider. This provision shall be consistent
19 with Section 356z.3a of the Illinois Insurance Code.
20 (8) A limitation that complies with subsections (d)
21 and (e) of Section 55 of the Prior Authorization Reform
22 Act.
23 (c) The network plan shall demonstrate to the Director a
24 minimum ratio of providers to plan beneficiaries as required
25 by the Department.
26 (1) The ratio of physicians or other providers to plan

1 beneficiaries shall be established annually by the
2 Department in consultation with the Department of Public
3 Health based upon the guidance from the federal Centers
4 for Medicare and Medicaid Services. The Department shall
5 not establish ratios for vision or dental providers who
6 provide services under dental-specific or vision-specific
7 benefits. The Department shall consider establishing
8 ratios for the following physicians or other providers:
9 (A) Primary Care;
10 (B) Pediatrics;
11 (C) Cardiology;
12 (D) Gastroenterology;
13 (E) General Surgery;
14 (F) Neurology;
15 (G) OB/GYN;
16 (H) Oncology/Radiation;
17 (I) Ophthalmology;
18 (J) Urology;
19 (K) Behavioral Health;
20 (L) Allergy/Immunology;
21 (M) Chiropractic;
22 (N) Dermatology;
23 (O) Endocrinology;
24 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
25 (Q) Infectious Disease;
26 (R) Nephrology;

1 (S) Neurosurgery;
2 (T) Orthopedic Surgery;
3 (U) Physiatry/Rehabilitative;
4 (V) Plastic Surgery;
5 (W) Pulmonary;
6 (X) Rheumatology;
7 (Y) Anesthesiology;
8 (Z) Pain Medicine;
9 (AA) Pediatric Specialty Services;
10 (BB) Outpatient Dialysis; and
11 (CC) HIV.
12 (2) The Director shall establish a process for the
13 review of the adequacy of these standards, along with an
14 assessment of additional specialties to be included in the
15 list under this subsection (c).
16 (d) The network plan shall demonstrate to the Director
17 maximum travel and distance standards for plan beneficiaries,
18 which shall be established annually by the Department in
19 consultation with the Department of Public Health based upon
20 the guidance from the federal Centers for Medicare and
21 Medicaid Services. These standards shall consist of the
22 maximum minutes or miles to be traveled by a plan beneficiary
23 for each county type, such as large counties, metro counties,
24 or rural counties as defined by Department rule.
25 The maximum travel time and distance standards must
26 include standards for each physician and other provider

1 category listed for which ratios have been established.
2 The Director shall establish a process for the review of
3 the adequacy of these standards along with an assessment of
4 additional specialties to be included in the list under this
5 subsection (d).
6 (d-5)(1) Every insurer shall ensure that beneficiaries
7 have timely and proximate access to treatment for mental,
8 emotional, nervous, or substance use disorders or conditions
9 in accordance with the provisions of paragraph (4) of
10 subsection (a) of Section 370c of the Illinois Insurance Code.
11 Insurers shall use a comparable process, strategy, evidentiary
12 standard, and other factors in the development and application
13 of the network adequacy standards for timely and proximate
14 access to treatment for mental, emotional, nervous, or
15 substance use disorders or conditions and those for the access
16 to treatment for medical and surgical conditions. As such, the
17 network adequacy standards for timely and proximate access
18 shall equally be applied to treatment facilities and providers
19 for mental, emotional, nervous, or substance use disorders or
20 conditions and specialists providing medical or surgical
21 benefits pursuant to the parity requirements of Section 370c.1
22 of the Illinois Insurance Code and the federal Paul Wellstone
23 and Pete Domenici Mental Health Parity and Addiction Equity
24 Act of 2008. Notwithstanding the foregoing, the network
25 adequacy standards for timely and proximate access to
26 treatment for mental, emotional, nervous, or substance use

1 disorders or conditions shall, at a minimum, satisfy the
2 following requirements:
3 (A) For beneficiaries residing in the metropolitan
4 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
5 network adequacy standards for timely and proximate access
6 to treatment for mental, emotional, nervous, or substance
7 use disorders or conditions means a beneficiary shall not
8 have to travel longer than 30 minutes or 30 miles from the
9 beneficiary's residence to receive outpatient treatment
10 for mental, emotional, nervous, or substance use disorders
11 or conditions. Beneficiaries shall not be required to wait
12 longer than 10 business days between requesting an initial
13 appointment and being seen by the facility or provider of
14 mental, emotional, nervous, or substance use disorders or
15 conditions for outpatient treatment or to wait longer than
16 20 business days between requesting a repeat or follow-up
17 appointment and being seen by the facility or provider of
18 mental, emotional, nervous, or substance use disorders or
19 conditions for outpatient treatment; however, subject to
20 the protections of paragraph (3) of this subsection, a
21 network plan shall not be held responsible if the
22 beneficiary or provider voluntarily chooses to schedule an
23 appointment outside of these required time frames.
24 (B) For beneficiaries residing in Illinois counties
25 other than those counties listed in subparagraph (A) of
26 this paragraph, network adequacy standards for timely and

proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use

disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios, ~~and~~ time and distance standards, and appointment wait-time standards established under this Act or federal law ~~by the Department~~ may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific

time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

1 (Text of Section from P.A. 103-718)
2 Sec. 10. Network adequacy.
3 (a) An insurer providing a network plan shall file a
4 description of all of the following with the Director:
5 (1) The written policies and procedures for adding
6 providers to meet patient needs based on increases in the
7 number of beneficiaries, changes in the
8 patient-to-provider ratio, changes in medical and health
9 care capabilities, and increased demand for services.
10 (2) The written policies and procedures for making
11 referrals within and outside the network.
12 (3) The written policies and procedures on how the
13 network plan will provide 24-hour, 7-day per week access
14 to network-affiliated primary care, emergency services,
15 and obstetrical and gynecological health care
16 professionals.
17 An insurer shall not prohibit a preferred provider from
18 discussing any specific or all treatment options with
19 beneficiaries irrespective of the insurer's position on those
20 treatment options or from advocating on behalf of
21 beneficiaries within the utilization review, grievance, or
22 appeals processes established by the insurer in accordance
23 with any rights or remedies available under applicable State
24 or federal law.
25 (b) Insurers must file for review a description of the

services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the

1 health care needs and service demands of the currently
2 enrolled population;
3 (C) the travel and distance standards for plan
4 beneficiaries in county service areas; and
5 (D) a description of how the use of telemedicine,
6 telehealth, or mobile care services may be used to
7 partially meet the network adequacy standards, if
8 applicable.
9 (6) A provision ensuring that whenever a beneficiary
10 has made a good faith effort, as evidenced by accessing
11 the provider directory, calling the network plan, and
12 calling the provider, to utilize preferred providers for a
13 covered service and it is determined the insurer does not
14 have the appropriate preferred providers due to
15 insufficient number, type, unreasonable travel distance or
16 delay, or preferred providers refusing to provide a
17 covered service because it is contrary to the conscience
18 of the preferred providers, as protected by the Health
19 Care Right of Conscience Act, the insurer shall ensure,
20 directly or indirectly, by terms contained in the payer
21 contract, that the beneficiary will be provided the
22 covered service at no greater cost to the beneficiary than
23 if the service had been provided by a preferred provider.
24 This paragraph (6) does not apply to: (A) a beneficiary
25 who willfully chooses to access a non-preferred provider
26 for health care services available through the panel of

1 preferred providers, or (B) a beneficiary enrolled in a
2 health maintenance organization. In these circumstances,
3 the contractual requirements for non-preferred provider
4 reimbursements shall apply unless Section 356z.3a of the
5 Illinois Insurance Code requires otherwise. In no event
6 shall a beneficiary who receives care at a participating
7 health care facility be required to search for
8 participating providers under the circumstances described
9 in subsection (b) or (b-5) of Section 356z.3a of the
10 Illinois Insurance Code except under the circumstances
11 described in paragraph (2) of subsection (b-5).

12 (7) A provision that the beneficiary shall receive
13 emergency care coverage such that payment for this
14 coverage is not dependent upon whether the emergency
15 services are performed by a preferred or non-preferred
16 provider and the coverage shall be at the same benefit
17 level as if the service or treatment had been rendered by a
18 preferred provider. For purposes of this paragraph (7),
19 "the same benefit level" means that the beneficiary is
20 provided the covered service at no greater cost to the
21 beneficiary than if the service had been provided by a
22 preferred provider. This provision shall be consistent
23 with Section 356z.3a of the Illinois Insurance Code.

24 (8) A limitation that, if the plan provides that the
25 beneficiary will incur a penalty for failing to
26 pre-certify inpatient hospital treatment, the penalty may

1 not exceed $1,000 per occurrence in addition to the plan
2 cost-sharing provisions.
3 (c) The network plan shall demonstrate to the Director a
4 minimum ratio of providers to plan beneficiaries as required
5 by the Department.
6 (1) The ratio of physicians or other providers to plan
7 beneficiaries shall be established annually by the
8 Department in consultation with the Department of Public
9 Health based upon the guidance from the federal Centers
10 for Medicare and Medicaid Services. The Department shall
11 not establish ratios for vision or dental providers who
12 provide services under dental-specific or vision-specific
13 benefits. The Department shall consider establishing
14 ratios for the following physicians or other providers:
15 (A) Primary Care;
16 (B) Pediatrics;
17 (C) Cardiology;
18 (D) Gastroenterology;
19 (E) General Surgery;
20 (F) Neurology;
21 (G) OB/GYN;
22 (H) Oncology/Radiation;
23 (I) Ophthalmology;
24 (J) Urology;
25 (K) Behavioral Health;
26 (L) Allergy/Immunology;

1 (M) Chiropractic;
2 (N) Dermatology;
3 (O) Endocrinology;
4 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
5 (Q) Infectious Disease;
6 (R) Nephrology;
7 (S) Neurosurgery;
8 (T) Orthopedic Surgery;
9 (U) Physiatry/Rehabilitative;
10 (V) Plastic Surgery;
11 (W) Pulmonary;
12 (X) Rheumatology;
13 (Y) Anesthesiology;
14 (Z) Pain Medicine;
15 (AA) Pediatric Specialty Services;
16 (BB) Outpatient Dialysis; and
17 (CC) HIV.
18 (2) The Director shall establish a process for the
19 review of the adequacy of these standards, along with an
20 assessment of additional specialties to be included in the
21 list under this subsection (c).
22 (d) The network plan shall demonstrate to the Director
23 maximum travel and distance standards for plan beneficiaries,
24 which shall be established annually by the Department in
25 consultation with the Department of Public Health based upon
26 the guidance from the federal Centers for Medicare and

1 Medicaid Services. These standards shall consist of the
2 maximum minutes or miles to be traveled by a plan beneficiary
3 for each county type, such as large counties, metro counties,
4 or rural counties as defined by Department rule.

5 The maximum travel time and distance standards must
6 include standards for each physician and other provider
7 category listed for which ratios have been established.

8 The Director shall establish a process for the review of
9 the adequacy of these standards along with an assessment of
10 additional specialties to be included in the list under this
11 subsection (d).

12 (d-5)(1) Every insurer shall ensure that beneficiaries
13 have timely and proximate access to treatment for mental,
14 emotional, nervous, or substance use disorders or conditions
15 in accordance with the provisions of paragraph (4) of
16 subsection (a) of Section 370c of the Illinois Insurance Code.
17 Insurers shall use a comparable process, strategy, evidentiary
18 standard, and other factors in the development and application
19 of the network adequacy standards for timely and proximate
20 access to treatment for mental, emotional, nervous, or
21 substance use disorders or conditions and those for the access
22 to treatment for medical and surgical conditions. As such, the
23 network adequacy standards for timely and proximate access
24 shall equally be applied to treatment facilities and providers
25 for mental, emotional, nervous, or substance use disorders or
26 conditions and specialists providing medical or surgical

1 benefits pursuant to the parity requirements of Section 370c.1
2 of the Illinois Insurance Code and the federal Paul Wellstone
3 and Pete Domenici Mental Health Parity and Addiction Equity
4 Act of 2008. Notwithstanding the foregoing, the network
5 adequacy standards for timely and proximate access to
6 treatment for mental, emotional, nervous, or substance use
7 disorders or conditions shall, at a minimum, satisfy the
8 following requirements:

9 (A) For beneficiaries residing in the metropolitan
10 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
11 network adequacy standards for timely and proximate access
12 to treatment for mental, emotional, nervous, or substance
13 use disorders or conditions means a beneficiary shall not
14 have to travel longer than 30 minutes or 30 miles from the
15 beneficiary's residence to receive outpatient treatment
16 for mental, emotional, nervous, or substance use disorders
17 or conditions. Beneficiaries shall not be required to wait
18 longer than 10 business days between requesting an initial
19 appointment and being seen by the facility or provider of
20 mental, emotional, nervous, or substance use disorders or
21 conditions for outpatient treatment or to wait longer than
22 20 business days between requesting a repeat or follow-up
23 appointment and being seen by the facility or provider of
24 mental, emotional, nervous, or substance use disorders or
25 conditions for outpatient treatment; however, subject to
26 the protections of paragraph (3) of this subsection, a

network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties,

1 network adequacy standards for timely and proximate access to
2 treatment for mental, emotional, nervous, or substance use
3 disorders or conditions means a beneficiary shall not have to
4 travel longer than 60 minutes or 60 miles from the
5 beneficiary's residence to receive inpatient or residential
6 treatment for mental, emotional, nervous, or substance use
7 disorders or conditions.

8 (3) If there is no in-network facility or provider
9 available for a beneficiary to receive timely and proximate
10 access to treatment for mental, emotional, nervous, or
11 substance use disorders or conditions in accordance with the
12 network adequacy standards outlined in this subsection, the
13 insurer shall provide necessary exceptions to its network to
14 ensure admission and treatment with a provider or at a
15 treatment facility in accordance with the network adequacy
16 standards in this subsection.

17 (e) Except for network plans solely offered as a group
18 health plan, these ratio and time and distance standards apply
19 to the lowest cost-sharing tier of any tiered network.

20 (f) The network plan may consider use of other health care
21 service delivery options, such as telemedicine or telehealth,
22 mobile clinics, and centers of excellence, or other ways of
23 delivering care to partially meet the requirements set under
24 this Section.

25 (g) Except for the requirements set forth in subsection
26 (d-5), insurers who are not able to comply with the provider

1 ratios, ~~and~~ time and distance standards, and appointment
2 wait-time standards established under this Act or federal law
3 ~~by the Department~~ may request an exception to these
4 requirements from the Department. The Department may grant an
5 exception in the following circumstances:
6 (1) if no providers or facilities meet the specific
7 time and distance standard in a specific service area and
8 the insurer (i) discloses information on the distance and
9 travel time points that beneficiaries would have to travel
10 beyond the required criterion to reach the next closest
11 contracted provider outside of the service area and (ii)
12 provides contact information, including names, addresses,
13 and phone numbers for the next closest contracted provider
14 or facility;
15 (2) if patterns of care in the service area do not
16 support the need for the requested number of provider or
17 facility type and the insurer provides data on local
18 patterns of care, such as claims data, referral patterns,
19 or local provider interviews, indicating where the
20 beneficiaries currently seek this type of care or where
21 the physicians currently refer beneficiaries, or both; or
22 (3) other circumstances deemed appropriate by the
23 Department consistent with the requirements of this Act.
24 (h) Insurers are required to report to the Director any
25 material change to an approved network plan within 15 days
26 after the change occurs and any change that would result in

failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.
(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

(Text of Section from P.A. 103-777)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of

1 beneficiaries within the utilization review, grievance, or
2 appeals processes established by the insurer in accordance
3 with any rights or remedies available under applicable State
4 or federal law.

5 (b) Insurers must file for review a description of the
6 services to be offered through a network plan. The description
7 shall include all of the following:

8 (1) A geographic map of the area proposed to be served
9 by the plan by county service area and zip code, including
10 marked locations for preferred providers.

11 (2) As deemed necessary by the Department, the names,
12 addresses, phone numbers, and specialties of the providers
13 who have entered into preferred provider agreements under
14 the network plan.

15 (3) The number of beneficiaries anticipated to be
16 covered by the network plan.

17 (4) An Internet website and toll-free telephone number
18 for beneficiaries and prospective beneficiaries to access
19 current and accurate lists of preferred providers,
20 additional information about the plan, as well as any
21 other information required by Department rule.

22 (5) A description of how health care services to be
23 rendered under the network plan are reasonably accessible
24 and available to beneficiaries. The description shall
25 address all of the following:

26 (A) the type of health care services to be

1 provided by the network plan;
2 (B) the ratio of physicians and other providers to
3 beneficiaries, by specialty and including primary care
4 physicians and facility-based physicians when
5 applicable under the contract, necessary to meet the
6 health care needs and service demands of the currently
7 enrolled population;
8 (C) the travel and distance standards for plan
9 beneficiaries in county service areas; and
10 (D) a description of how the use of telemedicine,
11 telehealth, or mobile care services may be used to
12 partially meet the network adequacy standards, if
13 applicable.
14 (6) A provision ensuring that whenever a beneficiary
15 has made a good faith effort, as evidenced by accessing
16 the provider directory, calling the network plan, and
17 calling the provider, to utilize preferred providers for a
18 covered service and it is determined the insurer does not
19 have the appropriate preferred providers due to
20 insufficient number, type, unreasonable travel distance or
21 delay, or preferred providers refusing to provide a
22 covered service because it is contrary to the conscience
23 of the preferred providers, as protected by the Health
24 Care Right of Conscience Act, the insurer shall ensure,
25 directly or indirectly, by terms contained in the payer
26 contract, that the beneficiary will be provided the

covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a

preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

1 (F) Neurology;
2 (G) OB/GYN;
3 (H) Oncology/Radiation;
4 (I) Ophthalmology;
5 (J) Urology;
6 (K) Behavioral Health;
7 (L) Allergy/Immunology;
8 (M) Chiropractic;
9 (N) Dermatology;
10 (O) Endocrinology;
11 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
12 (Q) Infectious Disease;
13 (R) Nephrology;
14 (S) Neurosurgery;
15 (T) Orthopedic Surgery;
16 (U) Physiatry/Rehabilitative;
17 (V) Plastic Surgery;
18 (W) Pulmonary;
19 (X) Rheumatology;
20 (Y) Anesthesiology;
21 (Z) Pain Medicine;
22 (AA) Pediatric Specialty Services;
23 (BB) Outpatient Dialysis; and
24 (CC) HIV.
25 (2) The Director shall establish a process for the
26 review of the adequacy of these standards, along with an

1 assessment of additional specialties to be included in the
2 list under this subsection (c).
3 (3) If the federal Centers for Medicare and Medicaid
4 Services establishes minimum provider ratios for
5 stand-alone dental plans in the type of exchange in use in
6 this State for a given plan year, the Department shall
7 enforce those standards for stand-alone dental plans for
8 that plan year.
9 (d) The network plan shall demonstrate to the Director
10 maximum travel and distance standards for plan beneficiaries,
11 which shall be established annually by the Department in
12 consultation with the Department of Public Health based upon
13 the guidance from the federal Centers for Medicare and
14 Medicaid Services. These standards shall consist of the
15 maximum minutes or miles to be traveled by a plan beneficiary
16 for each county type, such as large counties, metro counties,
17 or rural counties as defined by Department rule.
18 The maximum travel time and distance standards must
19 include standards for each physician and other provider
20 category listed for which ratios have been established.
21 The Director shall establish a process for the review of
22 the adequacy of these standards along with an assessment of
23 additional specialties to be included in the list under this
24 subsection (d).
25 If the federal Centers for Medicare and Medicaid Services
26 establishes appointment wait-time standards for qualified

1 health plans, including stand-alone dental plans, in the type
2 of exchange in use in this State for a given plan year, the
3 Department shall enforce those standards for the same types of
4 qualified health plans for that plan year. If the federal
5 Centers for Medicare and Medicaid Services establishes time
6 and distance standards for stand-alone dental plans in the
7 type of exchange in use in this State for a given plan year,
8 the Department shall enforce those standards for stand-alone
9 dental plans for that plan year.

10 (d-5)(1) Every insurer shall ensure that beneficiaries
11 have timely and proximate access to treatment for mental,
12 emotional, nervous, or substance use disorders or conditions
13 in accordance with the provisions of paragraph (4) of
14 subsection (a) of Section 370c of the Illinois Insurance Code.
15 Insurers shall use a comparable process, strategy, evidentiary
16 standard, and other factors in the development and application
17 of the network adequacy standards for timely and proximate
18 access to treatment for mental, emotional, nervous, or
19 substance use disorders or conditions and those for the access
20 to treatment for medical and surgical conditions. As such, the
21 network adequacy standards for timely and proximate access
22 shall equally be applied to treatment facilities and providers
23 for mental, emotional, nervous, or substance use disorders or
24 conditions and specialists providing medical or surgical
25 benefits pursuant to the parity requirements of Section 370c.1
26 of the Illinois Insurance Code and the federal Paul Wellstone

1 and Pete Domenici Mental Health Parity and Addiction Equity
2 Act of 2008. Notwithstanding the foregoing, the network
3 adequacy standards for timely and proximate access to
4 treatment for mental, emotional, nervous, or substance use
5 disorders or conditions shall, at a minimum, satisfy the
6 following requirements:
7 (A) For beneficiaries residing in the metropolitan
8 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
9 network adequacy standards for timely and proximate access
10 to treatment for mental, emotional, nervous, or substance
11 use disorders or conditions means a beneficiary shall not
12 have to travel longer than 30 minutes or 30 miles from the
13 beneficiary's residence to receive outpatient treatment
14 for mental, emotional, nervous, or substance use disorders
15 or conditions. Beneficiaries shall not be required to wait
16 longer than 10 business days between requesting an initial
17 appointment and being seen by the facility or provider of
18 mental, emotional, nervous, or substance use disorders or
19 conditions for outpatient treatment or to wait longer than
20 20 business days between requesting a repeat or follow-up
21 appointment and being seen by the facility or provider of
22 mental, emotional, nervous, or substance use disorders or
23 conditions for outpatient treatment; however, subject to
24 the protections of paragraph (3) of this subsection, a
25 network plan shall not be held responsible if the
26 beneficiary or provider voluntarily chooses to schedule an

1 appointment outside of these required time frames.
2 (B) For beneficiaries residing in Illinois counties
3 other than those counties listed in subparagraph (A) of
4 this paragraph, network adequacy standards for timely and
5 proximate access to treatment for mental, emotional,
6 nervous, or substance use disorders or conditions means a
7 beneficiary shall not have to travel longer than 60
8 minutes or 60 miles from the beneficiary's residence to
9 receive outpatient treatment for mental, emotional,
10 nervous, or substance use disorders or conditions.
11 Beneficiaries shall not be required to wait longer than 10
12 business days between requesting an initial appointment
13 and being seen by the facility or provider of mental,
14 emotional, nervous, or substance use disorders or
15 conditions for outpatient treatment or to wait longer than
16 20 business days between requesting a repeat or follow-up
17 appointment and being seen by the facility or provider of
18 mental, emotional, nervous, or substance use disorders or
19 conditions for outpatient treatment; however, subject to
20 the protections of paragraph (3) of this subsection, a
21 network plan shall not be held responsible if the
22 beneficiary or provider voluntarily chooses to schedule an
23 appointment outside of these required time frames.
24 (2) For beneficiaries residing in all Illinois counties,
25 network adequacy standards for timely and proximate access to
26 treatment for mental, emotional, nervous, or substance use

1 disorders or conditions means a beneficiary shall not have to
2 travel longer than 60 minutes or 60 miles from the
3 beneficiary's residence to receive inpatient or residential
4 treatment for mental, emotional, nervous, or substance use
5 disorders or conditions.

6 (3) If there is no in-network facility or provider
7 available for a beneficiary to receive timely and proximate
8 access to treatment for mental, emotional, nervous, or
9 substance use disorders or conditions in accordance with the
10 network adequacy standards outlined in this subsection, the
11 insurer shall provide necessary exceptions to its network to
12 ensure admission and treatment with a provider or at a
13 treatment facility in accordance with the network adequacy
14 standards in this subsection.

15 (4) If the federal Centers for Medicare and Medicaid
16 Services establishes a more stringent standard in any county
17 than specified in paragraph (1) or (2) of this subsection
18 (d-5) for qualified health plans in the type of exchange in use
19 in this State for a given plan year, the federal standard shall
20 apply in lieu of the standard in paragraph (1) or (2) of this
21 subsection (d-5) for qualified health plans for that plan
22 year.

23 (e) Except for network plans solely offered as a group
24 health plan, these ratio and time and distance standards apply
25 to the lowest cost-sharing tier of any tiered network.

26 (f) The network plan may consider use of other health care

service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios, time and distance standards, and appointment wait-time standards established under this Act or federal law may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where

the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

(Text of Section from P.A. 103-906)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access

to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any

1 other information required by Department rule.
2 (5) A description of how health care services to be
3 rendered under the network plan are reasonably accessible
4 and available to beneficiaries. The description shall
5 address all of the following:
6 (A) the type of health care services to be
7 provided by the network plan;
8 (B) the ratio of physicians and other providers to
9 beneficiaries, by specialty and including primary care
10 physicians and facility-based physicians when
11 applicable under the contract, necessary to meet the
12 health care needs and service demands of the currently
13 enrolled population;
14 (C) the travel and distance standards for plan
15 beneficiaries in county service areas; and
16 (D) a description of how the use of telemedicine,
17 telehealth, or mobile care services may be used to
18 partially meet the network adequacy standards, if
19 applicable.
20 (6) A provision ensuring that whenever a beneficiary
21 has made a good faith effort, as evidenced by accessing
22 the provider directory, calling the network plan, and
23 calling the provider, to utilize preferred providers for a
24 covered service and it is determined the insurer does not
25 have the appropriate preferred providers due to
26 insufficient number, type, unreasonable travel distance or

1 delay, or preferred providers refusing to provide a
2 covered service because it is contrary to the conscience
3 of the preferred providers, as protected by the Health
4 Care Right of Conscience Act, the insurer shall ensure,
5 directly or indirectly, by terms contained in the payer
6 contract, that the beneficiary will be provided the
7 covered service at no greater cost to the beneficiary than
8 if the service had been provided by a preferred provider.
9 This paragraph (6) does not apply to: (A) a beneficiary
10 who willfully chooses to access a non-preferred provider
11 for health care services available through the panel of
12 preferred providers, or (B) a beneficiary enrolled in a
13 health maintenance organization. In these circumstances,
14 the contractual requirements for non-preferred provider
15 reimbursements shall apply unless Section 356z.3a of the
16 Illinois Insurance Code requires otherwise. In no event
17 shall a beneficiary who receives care at a participating
18 health care facility be required to search for
19 participating providers under the circumstances described
20 in subsection (b) or (b-5) of Section 356z.3a of the
21 Illinois Insurance Code except under the circumstances
22 described in paragraph (2) of subsection (b-5).

23 (7) A provision that the beneficiary shall receive
24 emergency care coverage such that payment for this
25 coverage is not dependent upon whether the emergency
26 services are performed by a preferred or non-preferred

1 provider and the coverage shall be at the same benefit
2 level as if the service or treatment had been rendered by a
3 preferred provider. For purposes of this paragraph (7),
4 "the same benefit level" means that the beneficiary is
5 provided the covered service at no greater cost to the
6 beneficiary than if the service had been provided by a
7 preferred provider. This provision shall be consistent
8 with Section 356z.3a of the Illinois Insurance Code.

9 (8) A limitation that, if the plan provides that the
10 beneficiary will incur a penalty for failing to
11 pre-certify inpatient hospital treatment, the penalty may
12 not exceed $1,000 per occurrence in addition to the plan
13 cost sharing provisions.

14 (c) The network plan shall demonstrate to the Director a
15 minimum ratio of providers to plan beneficiaries as required
16 by the Department.

17 (1) The ratio of physicians or other providers to plan
18 beneficiaries shall be established annually by the
19 Department in consultation with the Department of Public
20 Health based upon the guidance from the federal Centers
21 for Medicare and Medicaid Services. The Department shall
22 not establish ratios for vision or dental providers who
23 provide services under dental-specific or vision-specific
24 benefits. The Department shall consider establishing
25 ratios for the following physicians or other providers:

26 (A) Primary Care;

1 (B) Pediatrics;
2 (C) Cardiology;
3 (D) Gastroenterology;
4 (E) General Surgery;
5 (F) Neurology;
6 (G) OB/GYN;
7 (H) Oncology/Radiation;
8 (I) Ophthalmology;
9 (J) Urology;
10 (K) Behavioral Health;
11 (L) Allergy/Immunology;
12 (M) Chiropractic;
13 (N) Dermatology;
14 (O) Endocrinology;
15 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
16 (Q) Infectious Disease;
17 (R) Nephrology;
18 (S) Neurosurgery;
19 (T) Orthopedic Surgery;
20 (U) Physiatry/Rehabilitative;
21 (V) Plastic Surgery;
22 (W) Pulmonary;
23 (X) Rheumatology;
24 (Y) Anesthesiology;
25 (Z) Pain Medicine;
26 (AA) Pediatric Specialty Services;

1 (BB) Outpatient Dialysis; and
2 (CC) HIV.
3 (1.5) Beginning January 1, 2026, every insurer shall
4 demonstrate to the Director that each in-network hospital
5 has at least one radiologist, pathologist,
6 anesthesiologist, and emergency room physician as a
7 preferred provider in a network plan. The Department may,
8 by rule, require additional types of hospital-based
9 medical specialists to be included as preferred providers
10 in each in-network hospital in a network plan.
11 (2) The Director shall establish a process for the
12 review of the adequacy of these standards, along with an
13 assessment of additional specialties to be included in the
14 list under this subsection (c).
15 (d) The network plan shall demonstrate to the Director
16 maximum travel and distance standards for plan beneficiaries,
17 which shall be established annually by the Department in
18 consultation with the Department of Public Health based upon
19 the guidance from the federal Centers for Medicare and
20 Medicaid Services. These standards shall consist of the
21 maximum minutes or miles to be traveled by a plan beneficiary
22 for each county type, such as large counties, metro counties,
23 or rural counties as defined by Department rule.
24 The maximum travel time and distance standards must
25 include standards for each physician and other provider
26 category listed for which ratios have been established.

1 The Director shall establish a process for the review of
2 the adequacy of these standards along with an assessment of
3 additional specialties to be included in the list under this
4 subsection (d).
5 (d-5)(1) Every insurer shall ensure that beneficiaries
6 have timely and proximate access to treatment for mental,
7 emotional, nervous, or substance use disorders or conditions
8 in accordance with the provisions of paragraph (4) of
9 subsection (a) of Section 370c of the Illinois Insurance Code.
10 Insurers shall use a comparable process, strategy, evidentiary
11 standard, and other factors in the development and application
12 of the network adequacy standards for timely and proximate
13 access to treatment for mental, emotional, nervous, or
14 substance use disorders or conditions and those for the access
15 to treatment for medical and surgical conditions. As such, the
16 network adequacy standards for timely and proximate access
17 shall equally be applied to treatment facilities and providers
18 for mental, emotional, nervous, or substance use disorders or
19 conditions and specialists providing medical or surgical
20 benefits pursuant to the parity requirements of Section 370c.1
21 of the Illinois Insurance Code and the federal Paul Wellstone
22 and Pete Domenici Mental Health Parity and Addiction Equity
23 Act of 2008. Notwithstanding the foregoing, the network
24 adequacy standards for timely and proximate access to
25 treatment for mental, emotional, nervous, or substance use
26 disorders or conditions shall, at a minimum, satisfy the

1 following requirements:
2 (A) For beneficiaries residing in the metropolitan
3 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
4 network adequacy standards for timely and proximate access
5 to treatment for mental, emotional, nervous, or substance
6 use disorders or conditions means a beneficiary shall not
7 have to travel longer than 30 minutes or 30 miles from the
8 beneficiary's residence to receive outpatient treatment
9 for mental, emotional, nervous, or substance use disorders
10 or conditions. Beneficiaries shall not be required to wait
11 longer than 10 business days between requesting an initial
12 appointment and being seen by the facility or provider of
13 mental, emotional, nervous, or substance use disorders or
14 conditions for outpatient treatment or to wait longer than
15 20 business days between requesting a repeat or follow-up
16 appointment and being seen by the facility or provider of
17 mental, emotional, nervous, or substance use disorders or
18 conditions for outpatient treatment; however, subject to
19 the protections of paragraph (3) of this subsection, a
20 network plan shall not be held responsible if the
21 beneficiary or provider voluntarily chooses to schedule an
22 appointment outside of these required time frames.
23 (B) For beneficiaries residing in Illinois counties
24 other than those counties listed in subparagraph (A) of
25 this paragraph, network adequacy standards for timely and
26 proximate access to treatment for mental, emotional,

1 nervous, or substance use disorders or conditions means a
2 beneficiary shall not have to travel longer than 60
3 minutes or 60 miles from the beneficiary's residence to
4 receive outpatient treatment for mental, emotional,
5 nervous, or substance use disorders or conditions.
6 Beneficiaries shall not be required to wait longer than 10
7 business days between requesting an initial appointment
8 and being seen by the facility or provider of mental,
9 emotional, nervous, or substance use disorders or
10 conditions for outpatient treatment or to wait longer than
11 20 business days between requesting a repeat or follow-up
12 appointment and being seen by the facility or provider of
13 mental, emotional, nervous, or substance use disorders or
14 conditions for outpatient treatment; however, subject to
15 the protections of paragraph (3) of this subsection, a
16 network plan shall not be held responsible if the
17 beneficiary or provider voluntarily chooses to schedule an
18 appointment outside of these required time frames.
19 (2) For beneficiaries residing in all Illinois counties,
20 network adequacy standards for timely and proximate access to
21 treatment for mental, emotional, nervous, or substance use
22 disorders or conditions means a beneficiary shall not have to
23 travel longer than 60 minutes or 60 miles from the
24 beneficiary's residence to receive inpatient or residential
25 treatment for mental, emotional, nervous, or substance use
26 disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios, ~~and~~ time and distance standards, and appointment wait-time standards established under this Act or federal law ~~by the Department~~ may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and

1 the insurer (i) discloses information on the distance and
2 travel time points that beneficiaries would have to travel
3 beyond the required criterion to reach the next closest
4 contracted provider outside of the service area and (ii)
5 provides contact information, including names, addresses,
6 and phone numbers for the next closest contracted provider
7 or facility;
8 (2) if patterns of care in the service area do not
9 support the need for the requested number of provider or
10 facility type and the insurer provides data on local
11 patterns of care, such as claims data, referral patterns,
12 or local provider interviews, indicating where the
13 beneficiaries currently seek this type of care or where
14 the physicians currently refer beneficiaries, or both; or
15 (3) other circumstances deemed appropriate by the
16 Department consistent with the requirements of this Act.
17 (h) Insurers are required to report to the Director any
18 material change to an approved network plan within 15 days
19 after the change occurs and any change that would result in
20 failure to meet the requirements of this Act. Upon notice from
21 the insurer, the Director shall reevaluate the network plan's
22 compliance with the network adequacy and transparency
23 standards of this Act.
24 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
25 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

1 (215 ILCS 124/25)
2 (Text of Section from P.A. 103-605)
3 Sec. 25. Network transparency.
4 (a) A network plan shall post electronically an
5 up-to-date, accurate, and complete provider directory for each
6 of its network plans, with the information and search
7 functions, as described in this Section.
8 (1) In making the directory available electronically,
9 the network plans shall ensure that the general public is
10 able to view all of the current providers for a plan
11 through a clearly identifiable link or tab and without
12 creating or accessing an account or entering a policy or
13 contract number.
14 (2) The network plan shall update the online provider
15 directory at least monthly. Providers shall notify the
16 network plan electronically or in writing of any changes
17 to their information as listed in the provider directory,
18 including the information required in subparagraph (K) of
19 paragraph (1) of subsection (b). The network plan shall
20 update its online provider directory in a manner
21 consistent with the information provided by the provider
22 within 10 business days after being notified of the change
23 by the provider. Nothing in this paragraph (2) shall void
24 any contractual relationship between the provider and the
25 plan.
26 (3) The network plan shall audit periodically at least

1 25% of its provider directories for accuracy, make any
2 corrections necessary, and retain documentation of the
3 audit. The network plan shall submit the audit to the
4 Director upon request. As part of these audits, the
5 network plan shall contact any provider in its network
6 that has not submitted a claim to the plan or otherwise
7 communicated his or her intent to continue participation
8 in the plan's network.
9 (4) A network plan shall provide a printed copy of a
10 current provider directory or a printed copy of the
11 requested directory information upon request of a
12 beneficiary or a prospective beneficiary. Printed copies
13 must be updated quarterly and an errata that reflects
14 changes in the provider network must be updated quarterly.
15 (5) For each network plan, a network plan shall
16 include, in plain language in both the electronic and
17 print directory, the following general information:
18 (A) in plain language, a description of the
19 criteria the plan has used to build its provider
20 network;
21 (B) if applicable, in plain language, a
22 description of the criteria the insurer or network
23 plan has used to create tiered networks;
24 (C) if applicable, in plain language, how the
25 network plan designates the different provider tiers
26 or levels in the network and identifies for each

1 specific provider, hospital, or other type of facility
2 in the network which tier each is placed, for example,
3 by name, symbols, or grouping, in order for a
4 beneficiary-covered person or a prospective
5 beneficiary-covered person to be able to identify the
6 provider tier; and
7 (D) if applicable, a notation that authorization
8 or referral may be required to access some providers.
9 (6) A network plan shall make it clear for both its
10 electronic and print directories what provider directory
11 applies to which network plan, such as including the
12 specific name of the network plan as marketed and issued
13 in this State. The network plan shall include in both its
14 electronic and print directories a customer service email
15 address and telephone number or electronic link that
16 beneficiaries or the general public may use to notify the
17 network plan of inaccurate provider directory information
18 and contact information for the Department's Office of
19 Consumer Health Insurance.
20 (7) A provider directory, whether in electronic or
21 print format, shall accommodate the communication needs of
22 individuals with disabilities, and include a link to or
23 information regarding available assistance for persons
24 with limited English proficiency.
25 (b) For each network plan, a network plan shall make
26 available through an electronic provider directory the

1 following information in a searchable format:
2 (1) for health care professionals:
3 (A) name;
4 (B) gender;
5 (C) participating office locations;
6 (D) specialty, if applicable;
7 (E) medical group affiliations, if applicable;
8 (F) facility affiliations, if applicable;
9 (G) participating facility affiliations, if
10 applicable;
11 (H) languages spoken other than English, if
12 applicable;
13 (I) whether accepting new patients;
14 (J) board certifications, if applicable; and
15 (K) use of telehealth or telemedicine, including,
16 but not limited to:
17 (i) whether the provider offers the use of
18 telehealth or telemedicine to deliver services to
19 patients for whom it would be clinically
20 appropriate;
21 (ii) what modalities are used and what types
22 of services may be provided via telehealth or
23 telemedicine; and
24 (iii) whether the provider has the ability and
25 willingness to include in a telehealth or
26 telemedicine encounter a family caregiver who is

1 in a separate location than the patient if the
2 patient wishes and provides his or her consent;
3 (2) for hospitals:
4 (A) hospital name;
5 (B) hospital type (such as acute, rehabilitation,
6 children's, or cancer);
7 (C) participating hospital location; and
8 (D) hospital accreditation status; and
9 (3) for facilities, other than hospitals, by type:
10 (A) facility name;
11 (B) facility type;
12 (C) types of services performed; and
13 (D) participating facility location or locations.
14 (c) For the electronic provider directories, for each
15 network plan, a network plan shall make available all of the
16 following information in addition to the searchable
17 information required in this Section:
18 (1) for health care professionals:
19 (A) contact information; and
20 (B) languages spoken other than English by
21 clinical staff, if applicable;
22 (2) for hospitals, telephone number; and
23 (3) for facilities other than hospitals, telephone
24 number.
25 (d) The insurer or network plan shall make available in
26 print, upon request, the following provider directory

1 information for the applicable network plan:
2 (1) for health care professionals:
3 (A) name;
4 (B) contact information;
5 (C) participating office location or locations;
6 (D) specialty, if applicable;
7 (E) languages spoken other than English, if
8 applicable;
9 (F) whether accepting new patients; and
10 (G) use of telehealth or telemedicine, including,
11 but not limited to:
12 (i) whether the provider offers the use of
13 telehealth or telemedicine to deliver services to
14 patients for whom it would be clinically
15 appropriate;
16 (ii) what modalities are used and what types
17 of services may be provided via telehealth or
18 telemedicine; and
19 (iii) whether the provider has the ability and
20 willingness to include in a telehealth or
21 telemedicine encounter a family caregiver who is
22 in a separate location than the patient if the
23 patient wishes and provides his or her consent;
24 (2) for hospitals:
25 (A) hospital name;
26 (B) hospital type (such as acute, rehabilitation,

children's, or cancer); and

(C) participating hospital location and telephone number; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; and

(D) participating facility location or locations and telephone numbers.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the insurer's electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(Source: P.A. 102-92, eff. 7-9-21; 103-605, eff. 7-1-24.)

(Text of Section from P.A. 103-650)

1 Sec. 25. Network transparency.
2 (a) A network plan shall post electronically an
3 up-to-date, accurate, and complete provider directory for each
4 of its network plans, with the information and search
5 functions, as described in this Section.
6 (1) In making the directory available electronically,
7 the network plans shall ensure that the general public is
8 able to view all of the current providers for a plan
9 through a clearly identifiable link or tab and without
10 creating or accessing an account or entering a policy or
11 contract number.
12 (2) An issuer's failure to update a network plan's
13 directory shall subject the issuer to a civil penalty of
14 $5,000 per month. Providers shall notify the network plan
15 electronically or in writing within 10 business days of
16 any changes to their information as listed in the provider
17 directory, including the information required in
18 subsections (b), (c), and (d). With regard to subparagraph
19 (I) of paragraph (1) of subsection (b), the provider must
20 give notice to the issuer within 20 business days of
21 deciding to cease accepting new patients covered by the
22 plan if the new patient limitation is expected to last 40
23 business days or longer. The network plan shall update its
24 online provider directory in a manner consistent with the
25 information provided by the provider within 2 business
26 days after being notified of the change by the provider.

1 Nothing in this paragraph (2) shall void any contractual
2 relationship between the provider and the plan.
3 (3) At least once every 90 days, the issuer shall
4 self-audit each network plan's provider directories for
5 accuracy, make any corrections necessary, and retain
6 documentation of the audit. The issuer shall submit the
7 self-audit and a summary to the Department, and the
8 Department shall make the summary of each self-audit
9 publicly available. The Department shall specify the
10 requirements of the summary, which shall be statistical in
11 nature except for a high-level narrative evaluating the
12 impact of internal and external factors on the accuracy of
13 the directory and the timeliness of updates. As part of
14 these self-audits, the network plan shall contact any
15 provider in its network that has not submitted a claim to
16 the plan or otherwise communicated his or her intent to
17 continue participation in the plan's network. The
18 self-audits shall comply with 42 U.S.C. 300gg-115(a)(2),
19 except that "provider directory information" shall include
20 all information required to be included in a provider
21 directory pursuant to this Act.
22 (4) A network plan shall provide a print copy of a
23 current provider directory or a print copy of the
24 requested directory information upon request of a
25 beneficiary or a prospective beneficiary. Except when an
26 issuer's print copies use the same provider information as

1 the electronic provider directory on each print copy's
2 date of printing, print copies must be updated at least
3 every 90 days and errata that reflects changes in the
4 provider network must be included in each update.
5 (5) For each network plan, a network plan shall
6 include, in plain language in both the electronic and
7 print directory, the following general information:
8 (A) in plain language, a description of the
9 criteria the plan has used to build its provider
10 network;
11 (B) if applicable, in plain language, a
12 description of the criteria the issuer or network plan
13 has used to create tiered networks;
14 (C) if applicable, in plain language, how the
15 network plan designates the different provider tiers
16 or levels in the network and identifies for each
17 specific provider, hospital, or other type of facility
18 in the network which tier each is placed, for example,
19 by name, symbols, or grouping, in order for a
20 beneficiary-covered person or a prospective
21 beneficiary-covered person to be able to identify the
22 provider tier;
23 (D) if applicable, a notation that authorization
24 or referral may be required to access some providers;
25 (E) a telephone number and email address for a
26 customer service representative to whom directory

1 inaccuracies may be reported; and
2 (F) a detailed description of the process to
3 dispute charges for out-of-network providers,
4 hospitals, or facilities that were incorrectly listed
5 as in-network prior to the provision of care and a
6 telephone number and email address to dispute such
7 charges.
8 (6) A network plan shall make it clear for both its
9 electronic and print directories what provider directory
10 applies to which network plan, such as including the
11 specific name of the network plan as marketed and issued
12 in this State. The network plan shall include in both its
13 electronic and print directories a customer service email
14 address and telephone number or electronic link that
15 beneficiaries or the general public may use to notify the
16 network plan of inaccurate provider directory information
17 and contact information for the Department's Office of
18 Consumer Health Insurance.
19 (7) A provider directory, whether in electronic or
20 print format, shall accommodate the communication needs of
21 individuals with disabilities, and include a link to or
22 information regarding available assistance for persons
23 with limited English proficiency.
24 (b) For each network plan, a network plan shall make
25 available through an electronic provider directory the
26 following information in a searchable format:

1 (1) for health care professionals:
2 (A) name;
3 (B) gender;
4 (C) participating office locations;
5 (D) patient population served (such as pediatric,
6 adult, elderly, or women) and specialty or
7 subspecialty, if applicable;
8 (E) medical group affiliations, if applicable;
9 (F) facility affiliations, if applicable;
10 (G) participating facility affiliations, if
11 applicable;
12 (H) languages spoken other than English, if
13 applicable;
14 (I) whether accepting new patients;
15 (J) board certifications, if applicable;
16 (K) use of telehealth or telemedicine, including,
17 but not limited to:
18 (i) whether the provider offers the use of
19 telehealth or telemedicine to deliver services to
20 patients for whom it would be clinically
21 appropriate;
22 (ii) what modalities are used and what types
23 of services may be provided via telehealth or
24 telemedicine; and
25 (iii) whether the provider has the ability and
26 willingness to include in a telehealth or

1 telemedicine encounter a family caregiver who is
2 in a separate location than the patient if the
3 patient wishes and provides his or her consent;
4 (L) whether the health care professional accepts
5 appointment requests from patients; and
6 (M) the anticipated date the provider will leave
7 the network, if applicable, which shall be included no
8 more than 10 days after the issuer confirms that the
9 provider is scheduled to leave the network;
10 (2) for hospitals:
11 (A) hospital name;
12 (B) hospital type (such as acute, rehabilitation,
13 children's, or cancer);
14 (C) participating hospital location;
15 (D) hospital accreditation status; and
16 (E) the anticipated date the hospital will leave
17 the network, if applicable, which shall be included no
18 more than 10 days after the issuer confirms the
19 hospital is scheduled to leave the network; and
20 (3) for facilities, other than hospitals, by type:
21 (A) facility name;
22 (B) facility type;
23 (C) types of services performed;
24 (D) participating facility location or locations;
25 and
26 (E) the anticipated date the facility will leave

1 the network, if applicable, which shall be included no
2 more than 10 days after the issuer confirms the
3 facility is scheduled to leave the network.
4 (c) For the electronic provider directories, for each
5 network plan, a network plan shall make available all of the
6 following information in addition to the searchable
7 information required in this Section:
8 (1) for health care professionals:
9 (A) contact information, including both a
10 telephone number and digital contact information if
11 the provider has supplied digital contact information;
12 and
13 (B) languages spoken other than English by
14 clinical staff, if applicable;
15 (2) for hospitals, telephone number and digital
16 contact information; and
17 (3) for facilities other than hospitals, telephone
18 number.
19 (d) The issuer or network plan shall make available in
20 print, upon request, the following provider directory
21 information for the applicable network plan:
22 (1) for health care professionals:
23 (A) name;
24 (B) contact information, including a telephone
25 number and digital contact information if the provider
26 has supplied digital contact information;

1 (C) participating office location or locations;
2 (D) patient population (such as pediatric, adult,
3 elderly, or women) and specialty or subspecialty, if
4 applicable;
5 (E) languages spoken other than English, if
6 applicable;
7 (F) whether accepting new patients;
8 (G) use of telehealth or telemedicine, including,
9 but not limited to:
10 (i) whether the provider offers the use of
11 telehealth or telemedicine to deliver services to
12 patients for whom it would be clinically
13 appropriate;
14 (ii) what modalities are used and what types
15 of services may be provided via telehealth or
16 telemedicine; and
17 (iii) whether the provider has the ability and
18 willingness to include in a telehealth or
19 telemedicine encounter a family caregiver who is
20 in a separate location than the patient if the
21 patient wishes and provides his or her consent;
22 and
23 (H) whether the health care professional accepts
24 appointment requests from patients.
25 (2) for hospitals:
26 (A) hospital name;

1 (B) hospital type (such as acute, rehabilitation,
2 children's, or cancer); and
3 (C) participating hospital location, telephone
4 number, and digital contact information; and
5 (3) for facilities, other than hospitals, by type:
6 (A) facility name;
7 (B) facility type;
8 (C) patient population (such as pediatric, adult,
9 elderly, or women) served, if applicable, and types of
10 services performed; and
11 (D) participating facility location or locations,
12 telephone numbers, and digital contact information for
13 each location.
14 (e) The network plan shall include a disclosure in the
15 print format provider directory that the information included
16 in the directory is accurate as of the date of printing and
17 that beneficiaries or prospective beneficiaries should consult
18 the issuer's electronic provider directory on its website and
19 contact the provider. The network plan shall also include a
20 telephone number and email address in the print format
21 provider directory for a customer service representative where
22 the beneficiary can obtain current provider directory
23 information or report provider directory inaccuracies. The
24 printed provider directory shall include a detailed
25 description of the process to dispute charges for
26 out-of-network providers, hospitals, or facilities that were

1 incorrectly listed as in-network prior to the provision of
2 care and a telephone number and email address to dispute those
3 charges.
4 (f) The Director may conduct periodic audits of the
5 accuracy of provider directories. A network plan shall not be
6 subject to any fines or penalties for information required in
7 this Section that a provider submits that is inaccurate or
8 incomplete.
9 (g) To the extent not otherwise provided in this Act, an
10 issuer shall comply with the requirements of 42 U.S.C.
11 300gg-115, except that "provider directory information" shall
12 include all information required to be included in a provider
13 directory pursuant to this Section.
14 (h) If the issuer or the Department identifies a provider
15 incorrectly listed in the provider directory, the issuer shall
16 check each of the issuer's network plan provider directories
17 for the provider within 2 business days to ascertain whether
18 the provider is a preferred provider in that network plan and,
19 if the provider is incorrectly listed in the provider
20 directory, remove the provider from the provider directory
21 without delay.
22 (i) If the Director determines that an issuer violated
23 this Section, the Director may assess a fine up to $5,000 per
24 violation, except for inaccurate information given by a
25 provider to the issuer. If an issuer, or any entity or person
26 acting on the issuer's behalf, knew or reasonably should have

1 known that a provider was incorrectly included in a provider
2 directory, the Director may assess a fine of up to $25,000 per
3 violation against the issuer.
4 (j) This Section applies to network plans not otherwise
5 exempt under Section 3, including stand-alone dental plans.
6 (Source: P.A. 102-92, eff. 7-9-21; 103-650, eff. 1-1-25.)

7 (Text of Section from P.A. 103-777)
8 Sec. 25. Network transparency.
9 (a) A network plan shall post electronically an
10 up-to-date, accurate, and complete provider directory for each
11 of its network plans, with the information and search
12 functions, as described in this Section.
13 (1) In making the directory available electronically,
14 the network plans shall ensure that the general public is
15 able to view all of the current providers for a plan
16 through a clearly identifiable link or tab and without
17 creating or accessing an account or entering a policy or
18 contract number.
19 (2) The network plan shall update the online provider
20 directory at least monthly. Providers shall notify the
21 network plan electronically or in writing of any changes
22 to their information as listed in the provider directory,
23 including the information required in subparagraph (K) of
24 paragraph (1) of subsection (b). The network plan shall
25 update its online provider directory in a manner

1 consistent with the information provided by the provider
2 within 10 business days after being notified of the change
3 by the provider. Nothing in this paragraph (2) shall void
4 any contractual relationship between the provider and the
5 plan.
6 (3) The network plan shall audit periodically at least
7 25% of its provider directories for accuracy, make any
8 corrections necessary, and retain documentation of the
9 audit. The network plan shall submit the audit to the
10 Director upon request. As part of these audits, the
11 network plan shall contact any provider in its network
12 that has not submitted a claim to the plan or otherwise
13 communicated his or her intent to continue participation
14 in the plan's network.
15 (4) A network plan shall provide a printed copy of a
16 current provider directory or a printed copy of the
17 requested directory information upon request of a
18 beneficiary or a prospective beneficiary. Printed copies
19 must be updated quarterly and an errata that reflects
20 changes in the provider network must be updated quarterly.
21 (5) For each network plan, a network plan shall
22 include, in plain language in both the electronic and
23 print directory, the following general information:
24 (A) in plain language, a description of the
25 criteria the plan has used to build its provider
26 network;

1 (B) if applicable, in plain language, a
2 description of the criteria the insurer or network
3 plan has used to create tiered networks;
4 (C) if applicable, in plain language, how the
5 network plan designates the different provider tiers
6 or levels in the network and identifies for each
7 specific provider, hospital, or other type of facility
8 in the network which tier each is placed, for example,
9 by name, symbols, or grouping, in order for a
10 beneficiary-covered person or a prospective
11 beneficiary-covered person to be able to identify the
12 provider tier; and
13 (D) if applicable, a notation that authorization
14 or referral may be required to access some providers.
15 (6) A network plan shall make it clear for both its
16 electronic and print directories what provider directory
17 applies to which network plan, such as including the
18 specific name of the network plan as marketed and issued
19 in this State. The network plan shall include in both its
20 electronic and print directories a customer service email
21 address and telephone number or electronic link that
22 beneficiaries or the general public may use to notify the
23 network plan of inaccurate provider directory information
24 and contact information for the Department's Office of
25 Consumer Health Insurance.
26 (7) A provider directory, whether in electronic or

1 print format, shall accommodate the communication needs of
2 individuals with disabilities, and include a link to or
3 information regarding available assistance for persons
4 with limited English proficiency.
5 (b) For each network plan, a network plan shall make
6 available through an electronic provider directory the
7 following information in a searchable format:
8 (1) for health care professionals:
9 (A) name;
10 (B) gender;
11 (C) participating office locations;
12 (D) specialty, if applicable;
13 (E) medical group affiliations, if applicable;
14 (F) facility affiliations, if applicable;
15 (G) participating facility affiliations, if
16 applicable;
17 (H) languages spoken other than English, if
18 applicable;
19 (I) whether accepting new patients;
20 (J) board certifications, if applicable; and
21 (K) use of telehealth or telemedicine, including,
22 but not limited to:
23 (i) whether the provider offers the use of
24 telehealth or telemedicine to deliver services to
25 patients for whom it would be clinically
26 appropriate;

1 (ii) what modalities are used and what types
2 of services may be provided via telehealth or
3 telemedicine; and
4 (iii) whether the provider has the ability and
5 willingness to include in a telehealth or
6 telemedicine encounter a family caregiver who is
7 in a separate location than the patient if the
8 patient wishes and provides his or her consent;
9 (2) for hospitals:
10 (A) hospital name;
11 (B) hospital type (such as acute, rehabilitation,
12 children's, or cancer);
13 (C) participating hospital location; and
14 (D) hospital accreditation status; and
15 (3) for facilities, other than hospitals, by type:
16 (A) facility name;
17 (B) facility type;
18 (C) types of services performed; and
19 (D) participating facility location or locations.
20 (c) For the electronic provider directories, for each
21 network plan, a network plan shall make available all of the
22 following information in addition to the searchable
23 information required in this Section:
24 (1) for health care professionals:
25 (A) contact information; and
26 (B) languages spoken other than English by

1 clinical staff, if applicable;
2 (2) for hospitals, telephone number; and
3 (3) for facilities other than hospitals, telephone
4 number.
5 (d) The insurer or network plan shall make available in
6 print, upon request, the following provider directory
7 information for the applicable network plan:
8 (1) for health care professionals:
9 (A) name;
10 (B) contact information;
11 (C) participating office location or locations;
12 (D) specialty, if applicable;
13 (E) languages spoken other than English, if
14 applicable;
15 (F) whether accepting new patients; and
16 (G) use of telehealth or telemedicine, including,
17 but not limited to:
18 (i) whether the provider offers the use of
19 telehealth or telemedicine to deliver services to
20 patients for whom it would be clinically
21 appropriate;
22 (ii) what modalities are used and what types
23 of services may be provided via telehealth or
24 telemedicine; and
25 (iii) whether the provider has the ability and
26 willingness to include in a telehealth or

1 telemedicine encounter a family caregiver who is
2 in a separate location than the patient if the
3 patient wishes and provides his or her consent;
4 (2) for hospitals:
5 (A) hospital name;
6 (B) hospital type (such as acute, rehabilitation,
7 children's, or cancer); and
8 (C) participating hospital location and telephone
9 number; and
10 (3) for facilities, other than hospitals, by type:
11 (A) facility name;
12 (B) facility type;
13 (C) types of services performed; and
14 (D) participating facility location or locations
15 and telephone numbers.
16 (e) The network plan shall include a disclosure in the
17 print format provider directory that the information included
18 in the directory is accurate as of the date of printing and
19 that beneficiaries or prospective beneficiaries should consult
20 the insurer's electronic provider directory on its website and
21 contact the provider. The network plan shall also include a
22 telephone number in the print format provider directory for a
23 customer service representative where the beneficiary can
24 obtain current provider directory information.
25 (f) The Director may conduct periodic audits of the
26 accuracy of provider directories. A network plan shall not be

subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) This Section applies to network plans ~~that are~~ not otherwise exempt under Section 3, including stand-alone dental plans~~ that are subject to provider directory requirements under federal law~~.

(Source: P.A. 102-92, eff. 7-9-21; 103-777, eff. 1-1-25.)

Section 23. 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)

(Text of Section before amendment by P.A. 103-808)

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, 143.31, 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, 355.6, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356u.10, 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.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40,

1 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47,
2 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55,
3 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62,
4 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69,
5 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76,
6 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,
7 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,
8 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)
9 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
10 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
11 Illinois Insurance Code.

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

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

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

20 (3) a corporation organized under the laws of another
21 state, 30% or more of the enrollees of which are residents
22 of this State, except a corporation subject to
23 substantially the same requirements in its state of
24 organization as is a "domestic company" under Article VIII
25 1/2 of the Illinois Insurance Code.

26 (c) In considering the merger, consolidation, or other

1 acquisition of control of a Health Maintenance Organization
2 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
3 (1) the Director shall give primary consideration to
4 the continuation of benefits to enrollees and the
5 financial conditions of the acquired Health Maintenance
6 Organization after the merger, consolidation, or other
7 acquisition of control takes effect;
8 (2)(i) the criteria specified in subsection (1)(b) of
9 Section 131.8 of the Illinois Insurance Code shall not
10 apply and (ii) the Director, in making his determination
11 with respect to the merger, consolidation, or other
12 acquisition of control, need not take into account the
13 effect on competition of the merger, consolidation, or
14 other acquisition of control;
15 (3) the Director shall have the power to require the
16 following information:
17 (A) certification by an independent actuary of the
18 adequacy of the reserves of the Health Maintenance
19 Organization sought to be acquired;
20 (B) pro forma financial statements reflecting the
21 combined balance sheets of the acquiring company and
22 the Health Maintenance Organization sought to be
23 acquired as of the end of the preceding year and as of
24 a date 90 days prior to the acquisition, as well as pro
25 forma financial statements reflecting projected
26 combined operation for a period of 2 years;

1 (C) a pro forma business plan detailing an
2 acquiring party's plans with respect to the operation
3 of the Health Maintenance Organization sought to be
4 acquired for a period of not less than 3 years; and
5 (D) such other information as the Director shall
6 require.
7 (d) The provisions of Article VIII 1/2 of the Illinois
8 Insurance Code and this Section 5-3 shall apply to the sale by
9 any health maintenance organization of greater than 10% of its
10 enrollee population (including, without limitation, the health
11 maintenance organization's right, title, and interest in and
12 to its health care certificates).
13 (e) In considering any management contract or service
14 agreement subject to Section 141.1 of the Illinois Insurance
15 Code, the Director (i) shall, in addition to the criteria
16 specified in Section 141.2 of the Illinois Insurance Code,
17 take into account the effect of the management contract or
18 service agreement on the continuation of benefits to enrollees
19 and the financial condition of the health maintenance
20 organization to be managed or serviced, and (ii) need not take
21 into account the effect of the management contract or service
22 agreement on competition.
23 (f) Except for small employer groups as defined in the
24 Small Employer Rating, Renewability and Portability Health
25 Insurance Act and except for medicare supplement policies as
26 defined in Section 363 of the Illinois Insurance Code, a

1 Health Maintenance Organization may by contract agree with a
2 group or other enrollment unit to effect refunds or charge
3 additional premiums under the following terms and conditions:
4 (i) the amount of, and other terms and conditions with
5 respect to, the refund or additional premium are set forth
6 in the group or enrollment unit contract agreed in advance
7 of the period for which a refund is to be paid or
8 additional premium is to be charged (which period shall
9 not be less than one year); and
10 (ii) the amount of the refund or additional premium
11 shall not exceed 20% of the Health Maintenance
12 Organization's profitable or unprofitable experience with
13 respect to the group or other enrollment unit for the
14 period (and, for purposes of a refund or additional
15 premium, the profitable or unprofitable experience shall
16 be calculated taking into account a pro rata share of the
17 Health Maintenance Organization's administrative and
18 marketing expenses, but shall not include any refund to be
19 made or additional premium to be paid pursuant to this
20 subsection (f)). The Health Maintenance Organization and
21 the group or enrollment unit may agree that the profitable
22 or unprofitable experience may be calculated taking into
23 account the refund period and the immediately preceding 2
24 plan years.
25 The Health Maintenance Organization shall include a
26 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,

1 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
2 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
3 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
4 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
5 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
6 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
7 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
8 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.
9 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

10 (Text of Section after amendment by P.A. 103-808)
11 Sec. 5-3. Insurance Code provisions.
12 (a) Health Maintenance Organizations shall be subject to
13 the provisions of Sections 133, 134, 136, 137, 139, 140,
14 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
15 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
16 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g,
17 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
18 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
19 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
20 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
21 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
22 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
23 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
24 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
25 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,

1 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
2 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,
3 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5,
4 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
5 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
6 paragraph (c) of subsection (2) of Section 367, and Articles
7 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
8 XXXIIB of the Illinois Insurance Code.
9 (b) For purposes of the Illinois Insurance Code, except
10 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
11 Health Maintenance Organizations in the following categories
12 are deemed to be "domestic companies":
13 (1) a corporation authorized under the Dental Service
14 Plan Act or the Voluntary Health Services Plans Act;
15 (2) a corporation organized under the laws of this
16 State; or
17 (3) a corporation organized under the laws of another
18 state, 30% or more of the enrollees of which are residents
19 of this State, except a corporation subject to
20 substantially the same requirements in its state of
21 organization as is a "domestic company" under Article VIII
22 1/2 of the Illinois Insurance Code.
23 (c) In considering the merger, consolidation, or other
24 acquisition of control of a Health Maintenance Organization
25 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
26 (1) the Director shall give primary consideration to

1 the continuation of benefits to enrollees and the
2 financial conditions of the acquired Health Maintenance
3 Organization after the merger, consolidation, or other
4 acquisition of control takes effect;
5 (2)(i) the criteria specified in subsection (1)(b) of
6 Section 131.8 of the Illinois Insurance Code shall not
7 apply and (ii) the Director, in making his determination
8 with respect to the merger, consolidation, or other
9 acquisition of control, need not take into account the
10 effect on competition of the merger, consolidation, or
11 other acquisition of control;
12 (3) the Director shall have the power to require the
13 following information:
14 (A) certification by an independent actuary of the
15 adequacy of the reserves of the Health Maintenance
16 Organization sought to be acquired;
17 (B) pro forma financial statements reflecting the
18 combined balance sheets of the acquiring company and
19 the Health Maintenance Organization sought to be
20 acquired as of the end of the preceding year and as of
21 a date 90 days prior to the acquisition, as well as pro
22 forma financial statements reflecting projected
23 combined operation for a period of 2 years;
24 (C) a pro forma business plan detailing an
25 acquiring party's plans with respect to the operation
26 of the Health Maintenance Organization sought to be

1 acquired for a period of not less than 3 years; and
2 (D) such other information as the Director shall
3 require.
4 (d) The provisions of Article VIII 1/2 of the Illinois
5 Insurance Code and this Section 5-3 shall apply to the sale by
6 any health maintenance organization of greater than 10% of its
7 enrollee population (including, without limitation, the health
8 maintenance organization's right, title, and interest in and
9 to its health care certificates).
10 (e) In considering any management contract or service
11 agreement subject to Section 141.1 of the Illinois Insurance
12 Code, the Director (i) shall, in addition to the criteria
13 specified in Section 141.2 of the Illinois Insurance Code,
14 take into account the effect of the management contract or
15 service agreement on the continuation of benefits to enrollees
16 and the financial condition of the health maintenance
17 organization to be managed or serviced, and (ii) need not take
18 into account the effect of the management contract or service
19 agreement on competition.
20 (f) Except for small employer groups as defined in the
21 Small Employer Rating, Renewability and Portability Health
22 Insurance Act and except for medicare supplement policies as
23 defined in Section 363 of the Illinois Insurance Code, a
24 Health Maintenance Organization may by contract agree with a
25 group or other enrollment unit to effect refunds or charge
26 additional premiums under the following terms and conditions:

1 (i) the amount of, and other terms and conditions with
2 respect to, the refund or additional premium are set forth
3 in the group or enrollment unit contract agreed in advance
4 of the period for which a refund is to be paid or
5 additional premium is to be charged (which period shall
6 not be less than one year); and
7 (ii) the amount of the refund or additional premium
8 shall not exceed 20% of the Health Maintenance
9 Organization's profitable or unprofitable experience with
10 respect to the group or other enrollment unit for the
11 period (and, for purposes of a refund or additional
12 premium, the profitable or unprofitable experience shall
13 be calculated taking into account a pro rata share of the
14 Health Maintenance Organization's administrative and
15 marketing expenses, but shall not include any refund to be
16 made or additional premium to be paid pursuant to this
17 subsection (f)). The Health Maintenance Organization and
18 the group or enrollment unit may agree that the profitable
19 or unprofitable experience may be calculated taking into
20 account the refund period and the immediately preceding 2
21 plan years.
22 The Health Maintenance Organization shall include a
23 statement in the evidence of coverage issued to each enrollee
24 describing the possibility of a refund or additional premium,
25 and upon request of any group or enrollment unit, provide to
26 the group or enrollment unit a description of the method used

1 to calculate (1) the Health Maintenance Organization's
2 profitable experience with respect to the group or enrollment
3 unit and the resulting refund to the group or enrollment unit
4 or (2) the Health Maintenance Organization's unprofitable
5 experience with respect to the group or enrollment unit and
6 the resulting additional premium to be paid by the group or
7 enrollment unit.

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

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

18 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
19 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
20 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
21 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
22 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
23 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
24 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
25 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
26 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; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 25. 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, 143.31, 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, 355d, 356m, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 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, 356z.71, 356z.73, 356z.74, 356z.75, 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, and XXXIIB of the Illinois Insurance Code. Nothing in this Section shall require a limited health care plan to cover any service

1 that is not a limited health service. For purposes of the
2 Illinois Insurance Code, except for Sections 444 and 444.1 and
3 Articles XIII and XIII 1/2, limited health service
4 organizations in the following categories are deemed to be
5 domestic companies:

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

7 (2) a corporation organized under the laws of another
8 state, 30% or more of the enrollees of which are residents
9 of this State, except a corporation subject to
10 substantially the same requirements in its state of
11 organization as is a domestic company under Article VIII
12 1/2 of the Illinois Insurance Code.

13 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
14 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.
15 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,
16 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
17 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
18 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
19 eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25;
20 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff.
21 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832,
22 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

23 Section 30. The Criminal Code of 2012 is amended by
24 changing Section 17-0.5 as follows:

1 (720 ILCS 5/17-0.5)
2 Sec. 17-0.5. Definitions. In this Article:
3 "Altered credit card or debit card" means any instrument
4 or device, whether known as a credit card or debit card, which
5 has been changed in any respect by addition or deletion of any
6 material, except for the signature by the person to whom the
7 card is issued.
8 "Cardholder" means the person or organization named on the
9 face of a credit card or debit card to whom or for whose
10 benefit the credit card or debit card is issued by an issuer.
11 "Computer" means a device that accepts, processes, stores,
12 retrieves, or outputs data and includes, but is not limited
13 to, auxiliary storage, including cloud-based networks of
14 remote services hosted on the Internet, and telecommunications
15 devices connected to computers.
16 "Computer network" means a set of related, remotely
17 connected devices and any communications facilities including
18 more than one computer with the capability to transmit data
19 between them through the communications facilities.
20 "Computer program" or "program" means a series of coded
21 instructions or statements in a form acceptable to a computer
22 which causes the computer to process data and supply the
23 results of the data processing.
24 "Computer services" means computer time or services,
25 including data processing services, Internet services,
26 electronic mail services, electronic message services, or

1 information or data stored in connection therewith.
2 "Counterfeit" means to manufacture, produce or create, by
3 any means, a credit card or debit card without the purported
4 issuer's consent or authorization.
5 "Credit card" means any instrument or device, whether
6 known as a credit card, credit plate, charge plate or any other
7 name, issued with or without fee by an issuer for the use of
8 the cardholder in obtaining money, goods, services or anything
9 else of value on credit or in consideration or an undertaking
10 or guaranty by the issuer of the payment of a check drawn by
11 the cardholder.
12 "Data" means a representation in any form of information,
13 knowledge, facts, concepts, or instructions, including program
14 documentation, which is prepared or has been prepared in a
15 formalized manner and is stored or processed in or transmitted
16 by a computer or in a system or network. Data is considered
17 property and may be in any form, including, but not limited to,
18 printouts, magnetic or optical storage media, punch cards, or
19 data stored internally in the memory of the computer.
20 "Debit card" means any instrument or device, known by any
21 name, issued with or without fee by an issuer for the use of
22 the cardholder in obtaining money, goods, services, and
23 anything else of value, payment of which is made against funds
24 previously deposited by the cardholder. A debit card which
25 also can be used to obtain money, goods, services and anything
26 else of value on credit shall not be considered a debit card

1 when it is being used to obtain money, goods, services or
2 anything else of value on credit.
3 "Document" includes, but is not limited to, any document,
4 representation, or image produced manually, electronically, or
5 by computer.
6 "Electronic fund transfer terminal" means any machine or
7 device that, when properly activated, will perform any of the
8 following services:
9 (1) Dispense money as a debit to the cardholder's
10 account; or
11 (2) Print the cardholder's account balances on a
12 statement; or
13 (3) Transfer funds between a cardholder's accounts; or
14 (4) Accept payments on a cardholder's loan; or
15 (5) Dispense cash advances on an open end credit or a
16 revolving charge agreement; or
17 (6) Accept deposits to a customer's account; or
18 (7) Receive inquiries of verification of checks and
19 dispense information that verifies that funds are
20 available to cover such checks; or
21 (8) Cause money to be transferred electronically from
22 a cardholder's account to an account held by any business,
23 firm, retail merchant, corporation, or any other
24 organization.
25 "Electronic funds transfer system", hereafter referred to
26 as "EFT System", means that system whereby funds are

1 transferred electronically from a cardholder's account to any
2 other account.
3 "Electronic mail service provider" means any person who
4 (i) is an intermediary in sending or receiving electronic mail
5 and (ii) provides to end-users of electronic mail services the
6 ability to send or receive electronic mail.
7 "Expired credit card or debit card" means a credit card or
8 debit card which is no longer valid because the term on it has
9 elapsed.
10 "False academic degree" means a certificate, diploma,
11 transcript, or other document purporting to be issued by an
12 institution of higher learning or purporting to indicate that
13 a person has completed an organized academic program of study
14 at an institution of higher learning when the person has not
15 completed the organized academic program of study indicated on
16 the certificate, diploma, transcript, or other document.
17 "False claim" means any statement made to any insurer,
18 purported insurer, servicing corporation, insurance broker, or
19 insurance agent, or any agent or employee of one of those
20 entities, and made as part of, or in support of, a claim for
21 payment or other benefit under a policy of insurance, or as
22 part of, or in support of, an application for the issuance of,
23 or the rating of, any insurance policy, when the statement
24 does any of the following:
25 (1) Contains any false, incomplete, or misleading
26 information concerning any fact or thing material to the

1 claim.

2 (2) Conceals (i) the occurrence of an event that is
3 material to any person's initial or continued right or
4 entitlement to any insurance benefit or payment or (ii)
5 the amount of any benefit or payment to which the person is
6 entitled.

7 "Financial institution" means any bank, savings and loan
8 association, credit union, or other depository of money or
9 medium of savings and collective investment.

10 "Governmental entity" means: each officer, board,
11 commission, and agency created by the Constitution, whether in
12 the executive, legislative, or judicial branch of State
13 government; each officer, department, board, commission,
14 agency, institution, authority, university, and body politic
15 and corporate of the State; each administrative unit or
16 corporate outgrowth of State government that is created by or
17 pursuant to statute, including units of local government and
18 their officers, school districts, and boards of election
19 commissioners; and each administrative unit or corporate
20 outgrowth of the foregoing items and as may be created by
21 executive order of the Governor.

22 "Incomplete credit card or debit card" means a credit card
23 or debit card which is missing part of the matter other than
24 the signature of the cardholder which an issuer requires to
25 appear on the credit card or debit card before it can be used
26 by a cardholder, and this includes credit cards or debit cards

which have not been stamped, embossed, imprinted or written on.

"Institution of higher learning" means a public or private college, university, or community college located in the State of Illinois that is authorized by the Board of Higher Education or the Illinois Community College Board to issue post-secondary degrees, or a public or private college, university, or community college located anywhere in the United States that is or has been legally constituted to offer degrees and instruction in its state of origin or incorporation.

"Insurance company" means any "company" as defined under Section 2 of the Illinois Insurance Code, "dental service plan corporation" as defined in Section 3 of the Dental Service Plan Act, "health maintenance organization" as defined in Section 1-2 of the Health Maintenance Organization Act, "limited health service organization" as defined in Section 1002 of the Limited Health Service Organization Act, "health services plan corporation" as defined in Section 2 of the Voluntary Health Services Plans Act, or any trust fund organized under the Religious and Charitable Risk Pooling Trust Act.

"Issuer" means the business organization or financial institution which issues a credit card or debit card, or its duly authorized agent.

"Merchant" has the meaning ascribed to it in Section

1 16-0.1 of this Code.
2 "Person" means any individual, corporation, government,
3 governmental subdivision or agency, business trust, estate,
4 trust, partnership or association or any other entity.
5 "Receives" or "receiving" means acquiring possession or
6 control.
7 "Record of charge form" means any document submitted or
8 intended to be submitted to an issuer as evidence of a credit
9 transaction for which the issuer has agreed to reimburse
10 persons providing money, goods, property, services or other
11 things of value.
12 "Revoked credit card or debit card" means a credit card or
13 debit card which is no longer valid because permission to use
14 it has been suspended or terminated by the issuer.
15 "Sale" means any delivery for value.
16 "Scheme or artifice to defraud" includes a scheme or
17 artifice to deprive another of the intangible right to honest
18 services.
19 "Self-insured entity" means any person, business,
20 partnership, corporation, or organization that sets aside
21 funds to meet his, her, or its losses or to absorb fluctuations
22 in the amount of loss, the losses being charged against the
23 funds set aside or accumulated.
24 "Social networking website" means an Internet website
25 containing profile web pages of the members of the website
26 that include the names or nicknames of such members,

1 photographs placed on the profile web pages by such members,
2 or any other personal or personally identifying information
3 about such members and links to other profile web pages on
4 social networking websites of friends or associates of such
5 members that can be accessed by other members or visitors to
6 the website. A social networking website provides members of
7 or visitors to such website the ability to leave messages or
8 comments on the profile web page that are visible to all or
9 some visitors to the profile web page and may also include a
10 form of electronic mail for members of the social networking
11 website.

12 "Statement" means any assertion, oral, written, or
13 otherwise, and includes, but is not limited to: any notice,
14 letter, or memorandum; proof of loss; bill of lading; receipt
15 for payment; invoice, account, or other financial statement;
16 estimate of property damage; bill for services; diagnosis or
17 prognosis; prescription; hospital, medical, or dental chart or
18 other record, x-ray, photograph, videotape, or movie film;
19 test result; other evidence of loss, injury, or expense;
20 computer-generated document; and data in any form.

21 "Universal Price Code Label" means a unique symbol that
22 consists of a machine-readable code and human-readable
23 numbers.

24 "With intent to defraud" means to act knowingly, and with
25 the specific intent to deceive or cheat, for the purpose of
26 causing financial loss to another or bringing some financial

1 gain to oneself, regardless of whether any person was actually
2 defrauded or deceived. This includes an intent to cause
3 another to assume, create, transfer, alter, or terminate any
4 right, obligation, or power with reference to any person or
5 property.
6 (Source: P.A. 101-87, eff. 1-1-20.)

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

14 Section 99. Effective date. This Act takes effect upon
15 becoming law, except that the changes to Sections 143d and
16 1563 of the Illinois Insurance Code take effect January 1,
17 2026, and the changes to Section 174 of the Illinois Insurance
18 Code take effect 60 days after this Act becomes law.

INDEX

Statutes amended in order of appearance

20 ILCS 1410/10	
215 ILCS 5/121-2.08	from Ch. 73, par. 733-2.08
215 ILCS 5/143d	from Ch. 73, par. 755d
215 ILCS 5/174	from Ch. 73, par. 786
215 ILCS 5/194	from Ch. 73, par. 806
215 ILCS 5/356z.73	
215 ILCS 5/368d	
215 ILCS 5/370c.1	
215 ILCS 5/1563	
215 ILCS 109/75	
215 ILCS 124/5	
215 ILCS 124/10	
215 ILCS 124/25	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 130/4003	from Ch. 73, par. 1504-3
720 ILCS 5/17-0.5	