



Sen. Laura Fine

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10400SB0708sam002

LRB104 07006 BAB 25722 a

1 AMENDMENT TO SENATE BILL 708

2 AMENDMENT NO. _____. Amend Senate Bill 708 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by
5 changing Sections 356z.14, 356z.40, and 370c and by adding
6 Section 355.7 as follows:

7 (215 ILCS 5/355.7 new)

8 Sec. 355.7. Medical loss ratio report and premium rebate.

9 (a) A health insurance issuer offering group or individual
10 health insurance coverage, including a grandfathered health
11 plan, shall, with respect to each plan year, submit to the
12 Director a report concerning the ratio of the incurred loss or
13 incurred claims plus the loss adjustment expense or change in
14 contract reserves to earned premiums. The report shall include
15 the percentage of total premium revenue, after accounting for
16 collections or receipts for risk adjustment and risk corridors

1 and payments of reinsurance, that such coverage expends:

2 (1) on reimbursement for clinical services provided to
3 enrollees under such coverage;

4 (2) for activities that improve health care quality;
5 and

6 (3) on all other non-claims costs, including an
7 explanation of the nature of such costs, and excluding
8 federal and State taxes and licensing or regulatory fees.

9 (b) A health insurance issuer shall comply with subsection
10 (a) by filing with the Director a copy of the report submitted
11 to the United States Department of Health and Human Services
12 under 42 U.S.C. 300gg-18, which must comply with federal
13 regulations promulgated thereunder. The Department shall make
14 the reports received under this Section available to the
15 public on its website.

16 (c) If 42 U.S.C. 300gg-18 or the federal regulations
17 promulgated thereunder are amended after January 15, 2025 to
18 repeal the reporting or rebate requirements, reduce the amount
19 or types of information required to be reported, or adopt a
20 calculation method that reduces the amount of rebates in this
21 State, a health insurance issuer shall file a supplemental
22 report with the Director or make supplemental rebate payments,
23 as applicable, for group or individual health insurance
24 coverage regulated by this State to ensure that the same total
25 information is filed with the Director and the same total
26 rebates are remitted to enrollees as before the federal

1 repeal, reduction, or recalculation took effect.

2 (d) Notwithstanding any other provision of this Section,
3 under no circumstances may the costs described in paragraphs
4 (1) and (2) of subsection (a) include:

5 (1) executive compensation beyond base salary;

6 (2) entity surplus or accumulated profit; or

7 (3) costs attendant with an application for lifestyle
8 management, weight loss, or wellness when the application
9 falls outside the scope of 45 CFR 158.140 through 158.160.

10 (e) This Section does not apply with respect to any policy
11 of excepted benefits as defined under 42 U.S.C. 300gg-91.

12 (f) Notwithstanding anything in this Section to the
13 contrary, this Section does not apply to policies issued or
14 delivered in this State that provide medical assistance under
15 the Illinois Public Aid Code or the Children's Health
16 Insurance Program Act.

17 (215 ILCS 5/356z.14)

18 Sec. 356z.14. Autism spectrum disorders.

19 (a) A group or individual policy of accident and health
20 insurance or managed care plan amended, delivered, issued, or
21 renewed after December 12, 2008 (the effective date of Public
22 Act 95-1005) must provide individuals under 21 years of age
23 coverage for the diagnosis of autism spectrum disorders and
24 for the treatment of autism spectrum disorders to the extent
25 that the diagnosis and treatment of autism spectrum disorders

1 are not already covered by the policy of accident and health
2 insurance or managed care plan.

3 (b) Coverage provided under this Section shall be subject
4 to a maximum benefit of \$36,000 per year, but shall not be
5 subject to any limits on the number of visits to a service
6 provider. ~~The After December 30, 2009, the~~ Director of ~~the~~
7 ~~Division of~~ Insurance shall, on an annual basis, adjust the
8 maximum benefit for inflation using the Medical Care Component
9 of the United States Department of Labor Consumer Price Index
10 for All Urban Consumers. Payments made by an insurer on behalf
11 of a covered individual for any care, treatment, intervention,
12 service, or item, the provision of which was for the treatment
13 of a health condition not diagnosed as an autism spectrum
14 disorder, shall not be applied toward any maximum benefit
15 established under this subsection.

16 (c) Coverage under this Section shall be subject to
17 copayment, deductible, and coinsurance provisions of a policy
18 of accident and health insurance or managed care plan to the
19 extent that other medical services covered by the policy of
20 accident and health insurance or managed care plan are subject
21 to these provisions.

22 (d) This Section shall not be construed as limiting
23 benefits that are otherwise available to an individual under a
24 policy of accident and health insurance or managed care plan
25 and benefits provided under this Section may not be subject to
26 dollar limits, deductibles, copayments, or coinsurance

1 provisions that are less favorable to the insured than the
2 dollar limits, deductibles, or coinsurance provisions that
3 apply to physical illness generally.

4 (e) An insurer may not deny or refuse to provide otherwise
5 covered services, or refuse to renew, refuse to reissue, or
6 otherwise terminate or restrict coverage under an individual
7 contract to provide services to an individual because the
8 individual or the individual's ~~their~~ dependent is diagnosed
9 with an autism spectrum disorder or due to the individual
10 utilizing benefits in this Section.

11 (e-5) An insurer may not deny or refuse to provide
12 otherwise covered services under a group or individual policy
13 of accident and health insurance or a managed care plan solely
14 because of the location wherein the clinically appropriate
15 services are provided.

16 (f) Upon request of the ~~reimbursing~~ insurer, a provider of
17 treatment for autism spectrum disorders shall furnish medical
18 records, clinical notes, or other necessary data that
19 substantiate that initial or continued medical treatment is
20 medically necessary and is resulting in improved clinical
21 status. When treatment is anticipated to require continued
22 services to achieve demonstrable progress, the insurer may
23 request a treatment plan consisting of diagnosis, proposed
24 treatment by type, frequency, anticipated duration of
25 treatment, the anticipated outcomes stated as goals, and the
26 frequency by which the treatment plan will be updated. Nothing

1 in this subsection supersedes the prohibition on prior
2 authorization for mental health treatment under subsection (w)
3 of Section 370c.

4 (g) When making a determination of medical necessity for a
5 treatment modality for autism spectrum disorders, an insurer
6 must make the determination in a manner that is consistent
7 with the manner used to make that determination with respect
8 to other diseases or illnesses covered under the policy,
9 including an appeals process. During the appeals process, any
10 challenge to medical necessity must be viewed as reasonable
11 only if the review includes a physician with expertise in the
12 most current and effective treatment modalities for autism
13 spectrum disorders.

14 (h) Coverage for medically necessary early intervention
15 services must be delivered by certified early intervention
16 specialists, as defined in 89 Ill. Adm. Code 500 and any
17 subsequent amendments thereto.

18 (h-5) If an individual has been diagnosed as having an
19 autism spectrum disorder, meeting the diagnostic criteria in
20 place at the time of diagnosis, and treatment is determined
21 medically necessary, then that individual shall remain
22 eligible for coverage under this Section even if subsequent
23 changes to the diagnostic criteria are adopted by the American
24 Psychiatric Association. If no changes to the diagnostic
25 criteria are adopted after April 1, 2012, and before December
26 31, 2014, then this subsection (h-5) shall be of no further

1 force and effect.

2 (h-10) An insurer may not deny or refuse to provide
3 covered services, or refuse to renew, refuse to reissue, or
4 otherwise terminate or restrict coverage under an individual
5 contract, for a person diagnosed with an autism spectrum
6 disorder on the basis that the individual declined an
7 alternative medication or covered service when the
8 individual's health care provider has determined that such
9 medication or covered service may exacerbate clinical
10 symptomatology and is medically contraindicated for the
11 individual and the individual has requested and received a
12 medical exception as provided for under Section 45.1 of the
13 Managed Care Reform and Patient Rights Act. For the purposes
14 of this subsection (h-10), "clinical symptomatology" means any
15 indication of disorder or disease when experienced by an
16 individual as a change from normal function, sensation, or
17 appearance.

18 (h-15) If, at any time, the Secretary of the United States
19 Department of Health and Human Services, or its successor
20 agency, promulgates rules or regulations to be published in
21 the Federal Register or publishes a comment in the Federal
22 Register or issues an opinion, guidance, or other action that
23 would require the State, pursuant to any provision of the
24 Patient Protection and Affordable Care Act (Public Law
25 111-148), including, but not limited to, 42 U.S.C.
26 18031(d) (3) (B) or any successor provision, to defray the cost

1 of any coverage outlined in subsection (h-10), then subsection
2 (h-10) is inoperative with respect to all coverage outlined in
3 subsection (h-10) other than that authorized under Section
4 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State
5 shall not assume any obligation for the cost of the coverage
6 set forth in subsection (h-10).

7 (i) As used in this Section:

8 "Autism spectrum disorders" means pervasive developmental
9 disorders as defined in the most recent edition of the
10 Diagnostic and Statistical Manual of Mental Disorders,
11 including autism, Asperger's disorder, and pervasive
12 developmental disorder not otherwise specified.

13 "Diagnosis of autism spectrum disorders" means one or more
14 tests, evaluations, or assessments to diagnose whether an
15 individual has autism spectrum disorder that is prescribed,
16 performed, or ordered by (A) a physician licensed to practice
17 medicine in all its branches or (B) a licensed clinical
18 psychologist with expertise in diagnosing autism spectrum
19 disorders.

20 "Medically necessary" means any care, treatment,
21 intervention, service, or item which will or is reasonably
22 expected to do any of the following: (i) prevent the onset of
23 an illness, condition, injury, disease, or disability; (ii)
24 reduce or ameliorate the physical, mental, or developmental
25 effects of an illness, condition, injury, disease, or
26 disability; or (iii) assist to achieve or maintain maximum

1 functional activity in performing daily activities.

2 "Treatment for autism spectrum disorders" shall include
3 the following care prescribed, provided, or ordered for an
4 individual diagnosed with an autism spectrum disorder by (A) a
5 physician licensed to practice medicine in all its branches or
6 (B) a certified, registered, or licensed health care
7 professional with expertise in treating effects of autism
8 spectrum disorders when the care is determined to be medically
9 necessary and ordered by a physician licensed to practice
10 medicine in all its branches:

11 (1) Psychiatric care, meaning direct, consultative, or
12 diagnostic services provided by a licensed psychiatrist.

13 (2) Psychological care, meaning direct or consultative
14 services provided by a licensed psychologist.

15 (3) Habilitative or rehabilitative care, meaning
16 professional, counseling, and guidance services and
17 treatment programs, including applied behavior analysis,
18 that are intended to develop, maintain, and restore the
19 functioning of an individual. As used in this subsection
20 (i), "applied behavior analysis" means the design,
21 implementation, and evaluation of environmental
22 modifications using behavioral stimuli and consequences to
23 produce socially significant improvement in human
24 behavior, including the use of direct observation,
25 measurement, and functional analysis of the relations
26 between environment and behavior.

1 (4) Therapeutic care, including behavioral, speech,
2 occupational, and physical therapies that provide
3 treatment in the following areas: (i) self care and
4 feeding, (ii) pragmatic, receptive, and expressive
5 language, (iii) cognitive functioning, (iv) applied
6 behavior analysis, intervention, and modification, (v)
7 motor planning, and (vi) sensory processing.

8 (j) Rulemaking authority to implement this amendatory Act
9 of the 95th General Assembly, if any, is conditioned on the
10 rules being adopted in accordance with all provisions of the
11 Illinois Administrative Procedure Act and all rules and
12 procedures of the Joint Committee on Administrative Rules; any
13 purported rule not so adopted, for whatever reason, is
14 unauthorized.

15 (Source: P.A. 102-322, eff. 1-1-22; 103-154, eff. 6-30-23;
16 revised 7-23-24.)

17 (215 ILCS 5/356z.40)

18 (Text of Section before amendment by P.A. 103-701 and
19 103-720)

20 Sec. 356z.40. Pregnancy and postpartum coverage.

21 (a) An individual or group policy of accident and health
22 insurance or managed care plan amended, delivered, issued, or
23 renewed on or after October 8, 2021 (the effective date of
24 Public Act 102-665) ~~this amendatory Act of the 102nd General~~
25 ~~Assembly~~ shall provide coverage for pregnancy and newborn care

1 in accordance with 42 U.S.C. 18022(b) regarding essential
2 health benefits.

3 (b) Benefits under this Section shall be as follows:

4 (1) An individual who has been identified as
5 experiencing a high-risk pregnancy by the individual's
6 treating provider shall have access to clinically
7 appropriate case management programs. As used in this
8 subsection, "case management" means a mechanism to
9 coordinate and assure continuity of services, including,
10 but not limited to, health services, social services, and
11 educational services necessary for the individual. "Case
12 management" involves individualized assessment of needs,
13 planning of services, referral, monitoring, and advocacy
14 to assist an individual in gaining access to appropriate
15 services and closure when services are no longer required.
16 "Case management" is an active and collaborative process
17 involving a single qualified case manager, the individual,
18 the individual's family, the providers, and the community.
19 This includes close coordination and involvement with all
20 service providers in the management plan for that
21 individual or family, including assuring that the
22 individual receives the services. As used in this
23 subsection, "high-risk pregnancy" means a pregnancy in
24 which the pregnant or postpartum individual or baby is at
25 an increased risk for poor health or complications during
26 pregnancy or childbirth, including, but not limited to,

1 hypertension disorders, gestational diabetes, and
2 hemorrhage.

3 (2) An individual shall have access to medically
4 necessary treatment of a mental, emotional, nervous, or
5 substance use disorder or condition consistent with the
6 requirements set forth in this Section and in Sections
7 370c and 370c.1 of this Code. Prior authorization
8 requirements are prohibited to the extent provided in
9 Section 370c.

10 (3) The benefits provided for inpatient and outpatient
11 services for the medically necessary treatment of a
12 mental, emotional, nervous, or substance use disorder or
13 condition related to pregnancy or postpartum complications
14 shall be provided ~~if determined to be medically necessary,~~
15 consistent with the requirements of Sections 370c and
16 370c.1 of this Code. The facility or provider shall notify
17 the insurer of both the admission and the initial
18 treatment plan within 48 hours after admission or
19 initiation of treatment. Subject to the requirements of
20 Sections 370c and 370c.1 of this Code, nothing in this
21 paragraph shall prevent an insurer from applying
22 concurrent and post-service utilization review of health
23 care services, including review of medical necessity, case
24 management, experimental and investigational treatments,
25 managed care provisions, and other terms and conditions of
26 the insurance policy.

1 (4) The benefits for the first 48 hours of initiation
2 of services for an inpatient admission, detoxification or
3 withdrawal management program, or partial hospitalization
4 admission for the treatment of a mental, emotional,
5 nervous, or substance use disorder or condition related to
6 pregnancy or postpartum complications shall be provided
7 without post-service or concurrent review of medical
8 necessity, as the medical necessity for the first 48 hours
9 of such services shall be determined solely by the covered
10 pregnant or postpartum individual's provider. Subject to
11 Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in
12 this paragraph shall prevent an insurer from applying
13 concurrent and post-service utilization review, including
14 the review of medical necessity, case management,
15 experimental and investigational treatments, managed care
16 provisions, and other terms and conditions of the
17 insurance policy, of any inpatient admission,
18 detoxification or withdrawal management program admission,
19 or partial hospitalization admission services for the
20 treatment of a mental, emotional, nervous, or substance
21 use disorder or condition related to pregnancy or
22 postpartum complications received 48 hours after the
23 initiation of such services. If an insurer determines that
24 the services are no longer medically necessary, then the
25 covered person shall have the right to external review
26 pursuant to the requirements of the Health Carrier

1 External Review Act.

2 (5) If an insurer determines that continued inpatient
3 care, detoxification or withdrawal management, partial
4 hospitalization, intensive outpatient treatment, or
5 outpatient treatment in a facility is no longer medically
6 necessary, the insurer shall, within 24 hours, provide
7 written notice to the covered pregnant or postpartum
8 individual and the covered pregnant or postpartum
9 individual's provider of its decision and the right to
10 file an expedited internal appeal of the determination.
11 The insurer shall review and make a determination with
12 respect to the internal appeal within 24 hours and
13 communicate such determination to the covered pregnant or
14 postpartum individual and the covered pregnant or
15 postpartum individual's provider. If the determination is
16 to uphold the denial, the covered pregnant or postpartum
17 individual and the covered pregnant or postpartum
18 individual's provider have the right to file an expedited
19 external appeal. An independent review organization shall
20 make a determination within 72 hours. If the insurer's
21 determination is upheld and it is determined that
22 continued inpatient care, detoxification or withdrawal
23 management, partial hospitalization, intensive outpatient
24 treatment, or outpatient treatment is not medically
25 necessary, or if the insurer's determination is not
26 appealed, the insurer shall remain responsible for

1 providing benefits for the inpatient care, detoxification
2 or withdrawal management, partial hospitalization,
3 intensive outpatient treatment, or outpatient treatment
4 through the day following the date the determination is
5 made, and the covered pregnant or postpartum individual
6 shall only be responsible for any applicable copayment,
7 deductible, and coinsurance for the stay through that date
8 as applicable under the policy. The covered pregnant or
9 postpartum individual shall not be discharged or released
10 from the inpatient facility, detoxification or withdrawal
11 management, partial hospitalization, intensive outpatient
12 treatment, or outpatient treatment until all internal
13 appeals and independent utilization review organization
14 appeals are exhausted. A decision to reverse an adverse
15 determination shall comply with the Health Carrier
16 External Review Act.

17 (6) Except as otherwise stated in this subsection (b),
18 the benefits and cost-sharing shall be provided to the
19 same extent as for any other medical condition covered
20 under the policy.

21 (7) The benefits required by paragraphs (2) and (6) of
22 this subsection (b) are to be provided to all covered
23 pregnant or postpartum individuals with a diagnosis of a
24 mental, emotional, nervous, or substance use disorder or
25 condition. The presence of additional related or unrelated
26 diagnoses shall not be a basis to reduce or deny the

1 benefits required by this subsection (b).

2 (Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25;
3 revised 9-10-24.)

4 (Text of Section after amendment by P.A. 103-701 and
5 103-720)

6 Sec. 356z.40. Pregnancy and postpartum coverage.

7 (a) An individual or group policy of accident and health
8 insurance or managed care plan amended, delivered, issued, or
9 renewed on or after October 8, 2021 (the effective date of
10 Public Act 102-665) shall provide coverage for pregnancy and
11 newborn care in accordance with 42 U.S.C. 18022(b) regarding
12 essential health benefits. For policies amended, delivered,
13 issued, or renewed on or after January 1, 2026, this
14 subsection also applies to coverage for postpartum care.

15 (b) Benefits under this Section shall be as follows:

16 (1) An individual who has been identified as
17 experiencing a high-risk pregnancy by the individual's
18 treating provider shall have access to clinically
19 appropriate case management programs. As used in this
20 subsection, "case management" means a mechanism to
21 coordinate and assure continuity of services, including,
22 but not limited to, health services, social services, and
23 educational services necessary for the individual. "Case
24 management" involves individualized assessment of needs,
25 planning of services, referral, monitoring, and advocacy

1 to assist an individual in gaining access to appropriate
2 services and closure when services are no longer required.
3 "Case management" is an active and collaborative process
4 involving a single qualified case manager, the individual,
5 the individual's family, the providers, and the community.
6 This includes close coordination and involvement with all
7 service providers in the management plan for that
8 individual or family, including assuring that the
9 individual receives the services. As used in this
10 subsection, "high-risk pregnancy" means a pregnancy in
11 which the pregnant or postpartum individual or baby is at
12 an increased risk for poor health or complications during
13 pregnancy or childbirth, including, but not limited to,
14 hypertension disorders, gestational diabetes, and
15 hemorrhage.

16 (2) An individual shall have access to medically
17 necessary treatment of a mental, emotional, nervous, or
18 substance use disorder or condition consistent with the
19 requirements set forth in this Section and in Sections
20 370c and 370c.1 of this Code. Prior authorization
21 requirements are prohibited to the extent provided in
22 Section 370c.

23 (3) The benefits provided for inpatient and outpatient
24 services for the medically necessary treatment of a
25 mental, emotional, nervous, or substance use disorder or
26 condition related to pregnancy or postpartum complications

1 shall be provided ~~if determined to be medically necessary,~~
2 consistent with the requirements of Sections 370c and
3 370c.1 of this Code. The facility or provider shall notify
4 the insurer of both the admission and the initial
5 treatment plan within 48 hours after admission or
6 initiation of treatment. Subject to the requirements of
7 Sections 370c and 370c.1 of this Code, nothing in this
8 paragraph shall prevent an insurer from applying
9 concurrent and post-service utilization review of health
10 care services, including review of medical necessity, case
11 management, experimental and investigational treatments,
12 managed care provisions, and other terms and conditions of
13 the insurance policy.

14 (4) The benefits for the first 48 hours of initiation
15 of services for an inpatient admission, detoxification or
16 withdrawal management program, or partial hospitalization
17 admission for the treatment of a mental, emotional,
18 nervous, or substance use disorder or condition related to
19 pregnancy or postpartum complications shall be provided
20 without post-service or concurrent review of medical
21 necessity, as the medical necessity for the first 48 hours
22 of such services shall be determined solely by the covered
23 pregnant or postpartum individual's provider. Subject to
24 Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in
25 this paragraph shall prevent an insurer from applying
26 concurrent and post-service utilization review, including

1 the review of medical necessity, case management,
2 experimental and investigational treatments, managed care
3 provisions, and other terms and conditions of the
4 insurance policy, of any inpatient admission,
5 detoxification or withdrawal management program admission,
6 or partial hospitalization admission services for the
7 treatment of a mental, emotional, nervous, or substance
8 use disorder or condition related to pregnancy or
9 postpartum complications received 48 hours after the
10 initiation of such services. If an insurer determines that
11 the services are no longer medically necessary, then the
12 covered person shall have the right to external review
13 pursuant to the requirements of the Health Carrier
14 External Review Act.

15 (5) If an insurer determines that continued inpatient
16 care, detoxification or withdrawal management, partial
17 hospitalization, intensive outpatient treatment, or
18 outpatient treatment in a facility is no longer medically
19 necessary, the insurer shall, within 24 hours, provide
20 written notice to the covered pregnant or postpartum
21 individual and the covered pregnant or postpartum
22 individual's provider of its decision and the right to
23 file an expedited internal appeal of the determination.
24 The insurer shall review and make a determination with
25 respect to the internal appeal within 24 hours and
26 communicate such determination to the covered pregnant or

1 postpartum individual and the covered pregnant or
2 postpartum individual's provider. If the determination is
3 to uphold the denial, the covered pregnant or postpartum
4 individual and the covered pregnant or postpartum
5 individual's provider have the right to file an expedited
6 external appeal. An independent review organization shall
7 make a determination within 72 hours. If the insurer's
8 determination is upheld and it is determined that
9 continued inpatient care, detoxification or withdrawal
10 management, partial hospitalization, intensive outpatient
11 treatment, or outpatient treatment is not medically
12 necessary, or if the insurer's determination is not
13 appealed, the insurer shall remain responsible for
14 providing benefits for the inpatient care, detoxification
15 or withdrawal management, partial hospitalization,
16 intensive outpatient treatment, or outpatient treatment
17 through the day following the date the determination is
18 made, and the covered pregnant or postpartum individual
19 shall only be responsible for any applicable copayment,
20 deductible, and coinsurance for the stay through that date
21 as applicable under the policy. The covered pregnant or
22 postpartum individual shall not be discharged or released
23 from the inpatient facility, detoxification or withdrawal
24 management, partial hospitalization, intensive outpatient
25 treatment, or outpatient treatment until all internal
26 appeals and independent utilization review organization

1 appeals are exhausted. A decision to reverse an adverse
2 determination shall comply with the Health Carrier
3 External Review Act.

4 (6) Except as otherwise stated in this subsection (b)
5 and subsection (c), the benefits and cost-sharing shall be
6 provided to the same extent as for any other medical
7 condition covered under the policy.

8 (7) The benefits required by paragraphs (2) and (6) of
9 this subsection (b) are to be provided to (i) all covered
10 pregnant or postpartum individuals with a diagnosis of a
11 mental, emotional, nervous, or substance use disorder or
12 condition and (ii) all individuals who have experienced a
13 miscarriage or stillbirth. The presence of additional
14 related or unrelated diagnoses shall not be a basis to
15 reduce or deny the benefits required by this subsection
16 (b).

17 (8) Insurers shall cover all services for pregnancy,
18 postpartum, and newborn care that are rendered by
19 perinatal doulas or licensed certified professional
20 midwives, including home births, home visits, and support
21 during labor, abortion, or miscarriage. Coverage shall
22 include the necessary equipment and medical supplies for a
23 home birth. For home visits by a perinatal doula, not
24 counting any home birth, the policy may limit coverage to
25 16 visits before and 16 visits after a birth, miscarriage,
26 or abortion, provided that the policy shall not be

1 required to cover more than \$8,000 for doula visits for
2 each pregnancy and subsequent postpartum period. As used
3 in this paragraph (8), "perinatal doula" has the meaning
4 given in subsection (a) of Section 5-18.5 of the Illinois
5 Public Aid Code.

6 (9) Coverage for pregnancy, postpartum, and newborn
7 care shall include home visits by lactation consultants
8 and the purchase of breast pumps and breast pump supplies,
9 including such breast pumps, breast pump supplies,
10 breastfeeding supplies, and feeding aids as recommended by
11 the lactation consultant. As used in this paragraph (9),
12 "lactation consultant" means an International
13 Board-Certified Lactation Consultant, a certified
14 lactation specialist with a certification from Lactation
15 Education Consultants, or a certified lactation counselor
16 as defined in subsection (a) of Section 5-18.10 of the
17 Illinois Public Aid Code.

18 (10) Coverage for postpartum services shall apply for
19 all covered services rendered within the first 12 months
20 after the end of pregnancy, subject to any policy
21 limitation on home visits by a perinatal doula allowed
22 under paragraph (8) of this subsection (b). Nothing in
23 this paragraph (10) shall be construed to require a policy
24 to cover services for an individual who is no longer
25 insured or enrolled under the policy. If an individual
26 becomes insured or enrolled under a new policy, the new

1 policy shall cover the individual consistent with the time
2 period and limitations allowed under this paragraph (10).
3 This paragraph (10) is subject to the requirements of
4 Section 25 of the Managed Care Reform and Patient Rights
5 Act, Section 20 of the Network Adequacy and Transparency
6 Act, and 42 U.S.C. 300gg-113.

7 (c) All coverage described in subsection (b), other than
8 health care services for home births, shall be provided
9 without cost-sharing, except that, for mental health services,
10 the cost-sharing prohibition does not apply to inpatient or
11 residential services, and, for substance use disorder
12 services, the cost-sharing prohibition applies only to levels
13 of treatment below and not including Level 3.1 (Clinically
14 Managed Low-Intensity Residential), as established by the
15 American Society for Addiction Medicine. This subsection does
16 not apply to the extent such coverage would disqualify a
17 high-deductible health plan from eligibility for a health
18 savings account pursuant to Section 223 of the Internal
19 Revenue Code.

20 (Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25;
21 103-701, eff. 1-1-26; 103-720, eff. 1-1-26; revised 11-26-24.)

22 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

23 Sec. 370c. Mental and emotional disorders.

24 (a) (1) On and after January 1, 2022 (the effective date of
25 Public Act 102-579), every insurer that amends, delivers,

1 issues, or renews group accident and health policies providing
2 coverage for hospital or medical treatment or services for
3 illness ~~on an expense-incurred basis~~ shall provide coverage
4 for the medically necessary treatment of mental, emotional,
5 nervous, or substance use disorders or conditions consistent
6 with the parity requirements of Section 370c.1 of this Code.

7 (2) Each insured that is covered for mental, emotional,
8 nervous, or substance use disorders or conditions shall be
9 free to select the physician licensed to practice medicine in
10 all its branches, licensed clinical psychologist, licensed
11 clinical social worker, licensed clinical professional
12 counselor, licensed marriage and family therapist, licensed
13 speech-language pathologist, or other licensed or certified
14 professional at a program licensed pursuant to the Substance
15 Use Disorder Act of his or her choice to treat such disorders,
16 and the insurer shall pay the covered charges of such
17 physician licensed to practice medicine in all its branches,
18 licensed clinical psychologist, licensed clinical social
19 worker, licensed clinical professional counselor, licensed
20 marriage and family therapist, licensed speech-language
21 pathologist, or other licensed or certified professional at a
22 program licensed pursuant to the Substance Use Disorder Act up
23 to the limits of coverage, provided (i) the disorder or
24 condition treated is covered by the policy, and (ii) the
25 physician, licensed psychologist, licensed clinical social
26 worker, licensed clinical professional counselor, licensed

1 marriage and family therapist, licensed speech-language
2 pathologist, or other licensed or certified professional at a
3 program licensed pursuant to the Substance Use Disorder Act is
4 authorized to provide said services under the statutes of this
5 State and in accordance with accepted principles of his or her
6 profession.

7 (3) Insofar as this Section applies solely to licensed
8 clinical social workers, licensed clinical professional
9 counselors, licensed marriage and family therapists, licensed
10 speech-language pathologists, and other licensed or certified
11 professionals at programs licensed pursuant to the Substance
12 Use Disorder Act, those persons who may provide services to
13 individuals shall do so after the licensed clinical social
14 worker, licensed clinical professional counselor, licensed
15 marriage and family therapist, licensed speech-language
16 pathologist, or other licensed or certified professional at a
17 program licensed pursuant to the Substance Use Disorder Act
18 has informed the patient of the desirability of the patient
19 conferring with the patient's primary care physician.

20 (4) "Mental, emotional, nervous, or substance use disorder
21 or condition" means a condition or disorder that involves a
22 mental health condition or substance use disorder that falls
23 under any of the diagnostic categories listed in the mental
24 and behavioral disorders chapter of the current edition of the
25 World Health Organization's International Classification of
26 Disease or that is listed in the most recent version of the

1 American Psychiatric Association's Diagnostic and Statistical
2 Manual of Mental Disorders. "Mental, emotional, nervous, or
3 substance use disorder or condition" includes any mental
4 health condition that occurs during pregnancy or during the
5 postpartum period and includes, but is not limited to,
6 postpartum depression.

7 (5) Medically necessary treatment and medical necessity
8 determinations shall be interpreted and made in a manner that
9 is consistent with and pursuant to subsections (h) through (y)
10 ~~(t)~~.

11 (b) (1) (Blank).

12 (2) (Blank).

13 (2.5) (Blank).

14 (3) Unless otherwise prohibited by federal law and
15 consistent with the parity requirements of Section 370c.1 of
16 this Code, the ~~reimbursing~~ insurer that amends, delivers,
17 issues, or renews a group or individual policy of accident and
18 health insurance, a qualified health plan offered through the
19 health insurance marketplace, or a provider of treatment of
20 mental, emotional, nervous, or substance use disorders or
21 conditions shall furnish medical records or other necessary
22 data that substantiate that initial or continued treatment is
23 at all times medically necessary. Nothing in this paragraph
24 (3) supersedes the prohibition on prior authorization
25 requirements to the extent provided under subsections (g) and
26 (w) and subparagraph (A) of paragraph (6.5) of this

1 subsection. ~~An insurer shall provide a mechanism for the~~
2 ~~timely review by a provider holding the same license and~~
3 ~~practicing in the same specialty as the patient's provider,~~
4 ~~who is unaffiliated with the insurer, jointly selected by the~~
5 ~~patient (or the patient's next of kin or legal representative~~
6 ~~if the patient is unable to act for himself or herself), the~~
7 ~~patient's provider, and the insurer in the event of a dispute~~
8 ~~between the insurer and patient's provider regarding the~~
9 ~~medical necessity of a treatment proposed by a patient's~~
10 ~~provider. If the reviewing provider determines the treatment~~
11 ~~to be medically necessary, the insurer shall provide~~
12 ~~reimbursement for the treatment. Future contractual or~~
13 ~~employment actions by the insurer regarding the patient's~~
14 ~~provider may not be based on the provider's participation in~~
15 ~~this procedure.~~ Nothing prevents the insured from agreeing in
16 writing to continue treatment at his or her expense. When
17 making a determination of the medical necessity for a
18 treatment modality for mental, emotional, nervous, or
19 substance use disorders or conditions, an insurer must make
20 the determination in a manner that is consistent with the
21 manner used to make that determination with respect to other
22 diseases or illnesses covered under the policy, including an
23 appeals process. Medical necessity determinations for
24 substance use disorders shall be made in accordance with
25 appropriate patient placement criteria established by the
26 American Society of Addiction Medicine. No additional criteria

1 may be used to make medical necessity determinations for
2 substance use disorders.

3 (4) A group health benefit plan amended, delivered,
4 issued, or renewed on or after January 1, 2019 (the effective
5 date of Public Act 100-1024) or an 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 on or after January 1, 2019 (the
9 effective date of Public Act 100-1024):

10 (A) shall provide coverage based upon medical
11 necessity for the treatment of a mental, emotional,
12 nervous, or substance use disorder or condition consistent
13 with the parity requirements of Section 370c.1 of this
14 Code; provided, however, that in each calendar year
15 coverage shall not be less than the following:

16 (i) 45 days of inpatient treatment; and

17 (ii) beginning on June 26, 2006 (the effective
18 date of Public Act 94-921), 60 visits for outpatient
19 treatment including group and individual outpatient
20 treatment; and

21 (iii) for plans or policies delivered, issued for
22 delivery, renewed, or modified after January 1, 2007
23 (the effective date of Public Act 94-906), 20
24 additional outpatient visits for speech therapy for
25 treatment of pervasive developmental disorders that
26 will be in addition to speech therapy provided

1 pursuant to item (ii) of this subparagraph (A); and

2 (B) may not include a lifetime limit on the number of
3 days of inpatient treatment or the number of outpatient
4 visits covered under the plan.

5 (C) (Blank).

6 (5) An issuer of a group health benefit plan or an
7 individual policy of accident and health insurance or a
8 qualified health plan offered through the health insurance
9 marketplace may not count toward the number of outpatient
10 visits required to be covered under this Section an outpatient
11 visit for the purpose of medication management and shall cover
12 the outpatient visits under the same terms and conditions as
13 it covers outpatient visits for the treatment of physical
14 illness.

15 (5.5) An individual or group health benefit plan amended,
16 delivered, issued, or renewed on or after September 9, 2015
17 (the effective date of Public Act 99-480) shall offer coverage
18 for medically necessary acute treatment services and medically
19 necessary clinical stabilization services. The treating
20 provider shall base all treatment recommendations and the
21 health benefit plan shall base all medical necessity
22 determinations for substance use disorders in accordance with
23 the most current edition of the Treatment Criteria for
24 Addictive, Substance-Related, and Co-Occurring Conditions
25 established by the American Society of Addiction Medicine. The
26 treating provider shall base all treatment recommendations and

1 the health benefit plan shall base all medical necessity
2 determinations for medication-assisted treatment in accordance
3 with the most current Treatment Criteria for Addictive,
4 Substance-Related, and Co-Occurring Conditions established by
5 the American Society of Addiction Medicine.

6 As used in this subsection:

7 "Acute treatment services" means 24-hour medically
8 supervised addiction treatment that provides evaluation and
9 withdrawal management and may include biopsychosocial
10 assessment, individual and group counseling, psychoeducational
11 groups, and discharge planning.

12 "Clinical stabilization services" means 24-hour treatment,
13 usually following acute treatment services for substance
14 abuse, which may include intensive education and counseling
15 regarding the nature of addiction and its consequences,
16 relapse prevention, outreach to families and significant
17 others, and aftercare planning for individuals beginning to
18 engage in recovery from addiction.

19 "Prior authorization" has the meaning given to that term
20 in Section 15 of the Prior Authorization Reform Act.

21 (6) An issuer of a group health benefit plan may provide or
22 offer coverage required under this Section through a managed
23 care plan.

24 (6.5) An individual or group health benefit plan amended,
25 delivered, issued, or renewed on or after January 1, 2019 (the
26 effective date of Public Act 100-1024):

1 (A) shall not impose prior authorization requirements,
2 including limitations on dosage, other than those
3 established under the Treatment Criteria for Addictive,
4 Substance-Related, and Co-Occurring Conditions
5 established by the American Society of Addiction Medicine,
6 on a prescription medication approved by the United States
7 Food and Drug Administration that is prescribed or
8 administered for the treatment of substance use disorders;

9 (B) shall not impose any step therapy requirements;

10 (C) shall place all prescription medications approved
11 by the United States Food and Drug Administration
12 prescribed or administered for the treatment of substance
13 use disorders on, for brand medications, the lowest tier
14 of the drug formulary developed and maintained by the
15 individual or group health benefit plan that covers brand
16 medications and, for generic medications, the lowest tier
17 of the drug formulary developed and maintained by the
18 individual or group health benefit plan that covers
19 generic medications; and

20 (D) shall not exclude coverage for a prescription
21 medication approved by the United States Food and Drug
22 Administration for the treatment of substance use
23 disorders and any associated counseling or wraparound
24 services on the grounds that such medications and services
25 were court ordered.

26 (7) (Blank).

1 (8) (Blank).

2 (9) With respect to all mental, emotional, nervous, or
3 substance use disorders or conditions, coverage for inpatient
4 treatment shall include coverage for treatment in a
5 residential treatment center certified or licensed by the
6 Department of Public Health or the Department of Human
7 Services.

8 (c) This Section shall not be interpreted to require
9 coverage for speech therapy or other habilitative services for
10 those individuals covered under Section 356z.15 of this Code.

11 (d) With respect to a group or individual policy of
12 accident and health insurance or a qualified health plan
13 offered through the health insurance marketplace, the
14 Department and, with respect to medical assistance, the
15 Department of Healthcare and Family Services shall each
16 enforce the requirements of this Section and Sections 356z.23
17 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
18 Mental Health Parity and Addiction Equity Act of 2008, 42
19 U.S.C. 18031(j), and any amendments to, and federal guidance
20 or regulations issued under, those Acts, including, but not
21 limited to, final regulations issued under the Paul Wellstone
22 and Pete Domenici Mental Health Parity and Addiction Equity
23 Act of 2008 and final regulations applying the Paul Wellstone
24 and Pete Domenici Mental Health Parity and Addiction Equity
25 Act of 2008 to Medicaid managed care organizations, the
26 Children's Health Insurance Program, and alternative benefit

1 plans. Specifically, the Department and the Department of
2 Healthcare and Family Services shall take action:

3 (1) proactively ensuring compliance by individual and
4 group policies, including by requiring that insurers
5 submit comparative analyses, as set forth in paragraph (6)
6 of subsection (k) of Section 370c.1, demonstrating how
7 they design and apply nonquantitative treatment
8 limitations, both as written and in operation, for mental,
9 emotional, nervous, or substance use disorder or condition
10 benefits as compared to how they design and apply
11 nonquantitative treatment limitations, as written and in
12 operation, for medical and surgical benefits;

13 (2) evaluating all consumer or provider complaints
14 regarding mental, emotional, nervous, or substance use
15 disorder or condition coverage for possible parity
16 violations;

17 (3) performing parity compliance market conduct
18 examinations or, in the case of the Department of
19 Healthcare and Family Services, parity compliance audits
20 of individual and group plans and policies, including, but
21 not limited to, reviews of:

22 (A) nonquantitative treatment limitations,
23 including, but not limited to, prior authorization
24 requirements, concurrent review, retrospective review,
25 step therapy, network admission standards,
26 reimbursement rates, and geographic restrictions;

1 (B) denials of authorization, payment, and
2 coverage; and

3 (C) other specific criteria as may be determined
4 by the Department.

5 The findings and the conclusions of the parity compliance
6 market conduct examinations and audits shall be made public.

7 The Director may adopt rules to effectuate any provisions
8 of the Paul Wellstone and Pete Domenici Mental Health Parity
9 and Addiction Equity Act of 2008 that relate to the business of
10 insurance.

11 (e) Availability of plan information.

12 (1) The criteria for medical necessity determinations
13 made under a group health plan, an individual policy of
14 accident and health insurance, or a qualified health plan
15 offered through the health insurance marketplace with
16 respect to mental health or substance use disorder
17 benefits (or health insurance coverage offered in
18 connection with the plan with respect to such benefits)
19 must be made available by the plan administrator (or the
20 health insurance issuer offering such coverage) to any
21 current or potential participant, beneficiary, or
22 contracting provider upon request.

23 (2) The reason for any denial under a group health
24 benefit plan, an individual policy of accident and health
25 insurance, or a qualified health plan offered through the
26 health insurance marketplace (or health insurance coverage

1 offered in connection with such plan or policy) of
2 reimbursement or payment for services with respect to
3 mental, emotional, nervous, or substance use disorders or
4 conditions benefits in the case of any participant or
5 beneficiary must be made available within a reasonable
6 time and in a reasonable manner and in readily
7 understandable language by the plan administrator (or the
8 health insurance issuer offering such coverage) to the
9 participant or beneficiary upon request.

10 (f) As used in this Section, "group policy of accident and
11 health insurance" and "group health benefit plan" includes (1)
12 State-regulated employer-sponsored group health insurance
13 plans written in Illinois or which purport to provide coverage
14 for a resident of this State; and (2) State, county,
15 municipal, or school district employee health plans.
16 References to an insurer include all plans described in this
17 subsection.

18 (g) (1) As used in this subsection:

19 "Benefits", with respect to insurers that are not Medicaid
20 managed care organizations, means the benefits provided for
21 treatment services for inpatient and outpatient treatment of
22 substance use disorders or conditions at American Society of
23 Addiction Medicine levels of treatment 2.1 (Intensive
24 Outpatient), 2.5 (High-Intensity Outpatient) ~~(Partial~~
25 ~~Hospitalization)~~, 3.1 (Clinically Managed Low-Intensity
26 Residential), ~~3.3 (Clinically Managed Population Specific~~

1 ~~High-Intensity Residential),~~ 3.5 (Clinically Managed
2 High-Intensity Residential), and 3.7 (Medically Managed
3 Residential Monitored Intensive Inpatient) and OMT (Opioid
4 Maintenance Therapy) services.

5 "Benefits", with respect to Medicaid managed care
6 organizations, means the benefits provided for treatment
7 services for inpatient and outpatient treatment of substance
8 use disorders or conditions at American Society of Addiction
9 Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5
10 (High-Intensity Outpatient) ~~(Partial Hospitalization)~~, 3.5
11 (Clinically Managed High-Intensity Residential), and 3.7
12 (Medically Managed Residential Monitored Intensive Inpatient)
13 and OMT (Opioid Maintenance Therapy) services.

14 "Substance use disorder treatment provider or facility"
15 means a licensed physician, licensed psychologist, licensed
16 psychiatrist, licensed advanced practice registered nurse, or
17 licensed, certified, or otherwise State-approved facility or
18 provider of substance use disorder treatment.

19 (2) A group health insurance policy, an individual health
20 benefit plan, or qualified health plan that is offered through
21 the health insurance marketplace, small employer group health
22 plan, and large employer group health plan that is amended,
23 delivered, issued, executed, or renewed in this State, or
24 approved for issuance or renewal in this State, on or after
25 January 1, 2019 (the effective date of Public Act 100-1023)
26 shall comply with the requirements of this Section and Section

1 370c.1. The services for the treatment and the ongoing
2 assessment of the patient's progress in treatment shall follow
3 the requirements of 77 Ill. Adm. Code 2060.

4 (3) Prior authorization shall not be utilized for the
5 benefits under this subsection. The substance use disorder
6 treatment provider or facility shall notify the insurer of the
7 initiation of treatment. For an insurer that is not a Medicaid
8 managed care organization, the substance use disorder
9 treatment provider or facility notification shall occur for
10 the initiation of treatment of the covered person within 2
11 business days. For Medicaid managed care organizations, the
12 substance use disorder treatment provider or facility
13 notification shall occur in accordance with the protocol set
14 forth in the provider agreement for initiation of treatment
15 within 24 hours. If the Medicaid managed care organization is
16 not capable of accepting the notification in accordance with
17 the contractual protocol during the 24-hour period following
18 admission, the substance use disorder treatment provider or
19 facility shall have one additional business day to provide the
20 notification to the appropriate managed care organization.
21 Treatment plans shall be developed in accordance with the
22 requirements and timeframes established in 77 Ill. Adm. Code
23 2060. No such coverage shall be subject to concurrent review
24 prior to the applicable notification deadline. If coverage is
25 denied retrospectively, neither the provider or facility nor
26 the insurer shall bill, and the covered individual shall not

1 be liable, for any treatment under this subsection through the
2 date the adverse determination is issued, other than any
3 copayment, coinsurance, or deductible for the treatment or
4 stay through that date as applicable under the policy.
5 Coverage shall not be retrospectively denied for benefits that
6 were furnished at a participating substance use disorder
7 facility prior to the applicable notification deadline except
8 for the following: If the substance use disorder treatment
9 provider or facility fails to notify the insurer of the
10 initiation of treatment in accordance with these provisions,
11 the insurer may follow its normal prior authorization
12 processes.

13 (A) upon reasonable determination that the benefits
14 were not provided;

15 (B) upon determination that the patient receiving the
16 treatment was not an insured, enrollee, or beneficiary
17 under the policy;

18 (C) upon material misrepresentation by the patient or
19 provider. As used in this subparagraph (C), "material"
20 means a fact or situation that is not merely technical in
21 nature and results or could result in a substantial change
22 in the situation;

23 (D) upon determination that a service was excluded
24 under the terms of coverage. For situations that qualify
25 under this subparagraph (D), the limitation to billing for
26 a copayment, coinsurance, or deductible shall not apply;

1 (E) upon determination that a service was not
2 medically necessary consistent with subsections (h)
3 through (n); or

4 (F) upon determination that the patient did not
5 consent to the treatment and that there was no court order
6 mandating the treatment.

7 (4) For an insurer that is not a Medicaid managed care
8 organization, if an insurer determines that benefits are no
9 longer medically necessary, the insurer shall notify the
10 covered person, the covered person's authorized
11 representative, if any, and the covered person's health care
12 provider in writing of the covered person's right to request
13 an external review pursuant to the Health Carrier External
14 Review Act. The notification shall occur within 24 hours
15 following the adverse determination.

16 Pursuant to the requirements of the Health Carrier
17 External Review Act, the covered person or the covered
18 person's authorized representative may request an expedited
19 external review. An expedited external review may not occur if
20 the substance use disorder treatment provider or facility
21 determines that continued treatment is no longer medically
22 necessary.

23 If an expedited external review request meets the criteria
24 of the Health Carrier External Review Act, an independent
25 review organization shall make a final determination of
26 medical necessity within 72 hours. If an independent review

1 organization upholds an adverse determination, an insurer
2 shall remain responsible to provide coverage of benefits
3 through the day following the determination of the independent
4 review organization. A decision to reverse an adverse
5 determination shall comply with the Health Carrier External
6 Review Act.

7 (5) The substance use disorder treatment provider or
8 facility shall provide the insurer with 7 business days'
9 advance notice of the planned discharge of the patient from
10 the substance use disorder treatment provider or facility and
11 notice on the day that the patient is discharged from the
12 substance use disorder treatment provider or facility.

13 (6) The benefits required by this subsection shall be
14 provided to all covered persons with a diagnosis of substance
15 use disorder or conditions. The presence of additional related
16 or unrelated diagnoses shall not be a basis to reduce or deny
17 the benefits required by this subsection.

18 (7) Nothing in this subsection shall be construed to
19 require an insurer to provide coverage for any of the benefits
20 in this subsection.

21 (8) Any concurrent or retrospective review permitted by
22 this subsection must be consistent with the utilization review
23 provisions in subsections (h) through (n).

24 (h) As used in this Section:

25 "Generally accepted standards of mental, emotional,
26 nervous, or substance use disorder or condition care" means

1 standards of care and clinical practice that are generally
2 recognized by health care providers practicing in relevant
3 clinical specialties such as psychiatry, psychology, clinical
4 sociology, social work, addiction medicine and counseling, and
5 behavioral health treatment. Valid, evidence-based sources
6 reflecting generally accepted standards of mental, emotional,
7 nervous, or substance use disorder or condition care include
8 peer-reviewed scientific studies and medical literature,
9 recommendations of nonprofit health care provider professional
10 associations and specialty societies, including, but not
11 limited to, patient placement criteria and clinical practice
12 guidelines, recommendations of federal government agencies,
13 and drug labeling approved by the United States Food and Drug
14 Administration.

15 "Medically necessary treatment of mental, emotional,
16 nervous, or substance use disorders or conditions" means a
17 service or product addressing the specific needs of that
18 patient, for the purpose of screening, preventing, diagnosing,
19 managing, or treating an illness, injury, or condition or its
20 symptoms and comorbidities, including minimizing the
21 progression of an illness, injury, or condition or its
22 symptoms and comorbidities in a manner that is all of the
23 following:

- 24 (1) in accordance with the generally accepted
25 standards of mental, emotional, nervous, or substance use
26 disorder or condition care;

1 (2) clinically appropriate in terms of type,
2 frequency, extent, site, and duration; and

3 (3) not primarily for the economic benefit of the
4 insurer, purchaser, or for the convenience of the patient,
5 treating physician, or other health care provider.

6 "Utilization review" means either of the following:

7 (1) prospectively, retrospectively, or concurrently
8 reviewing and approving, modifying, delaying, or denying,
9 based in whole or in part on medical necessity, requests
10 by health care providers, insureds, or their authorized
11 representatives for coverage of health care services
12 before, retrospectively, or concurrently with the
13 provision of health care services to insureds.

14 (2) evaluating the medical necessity, appropriateness,
15 level of care, service intensity, efficacy, or efficiency
16 of health care services, benefits, procedures, or
17 settings, under any circumstances, to determine whether a
18 health care service or benefit subject to a medical
19 necessity coverage requirement in an insurance policy is
20 covered as medically necessary for an insured.

21 "Utilization review criteria" means patient placement
22 criteria or any criteria, standards, protocols, or guidelines
23 used by an insurer to conduct utilization review.

24 (i)(1) Every insurer that amends, delivers, issues, or
25 renews a group or individual policy of accident and health
26 insurance or a qualified health plan offered through the

1 health insurance marketplace in this State and Medicaid
2 managed care organizations providing coverage for hospital or
3 medical treatment on or after January 1, 2023 shall, pursuant
4 to subsections (h) through (s), provide coverage for medically
5 necessary treatment of mental, emotional, nervous, or
6 substance use disorders or conditions.

7 (2) An insurer shall not set a specific limit on the
8 duration of benefits or coverage of medically necessary
9 treatment of mental, emotional, nervous, or substance use
10 disorders or conditions or limit coverage only to alleviation
11 of the insured's current symptoms.

12 (3) All utilization review conducted by the insurer
13 concerning diagnosis, prevention, and treatment of insureds
14 diagnosed with mental, emotional, nervous, or substance use
15 disorders or conditions shall be conducted in accordance with
16 the requirements of subsections (k) through (w).

17 (4) An insurer that authorizes a specific type of
18 treatment by a provider pursuant to this Section shall not
19 rescind or modify the authorization after that provider
20 renders the health care service in good faith and pursuant to
21 this authorization for any reason, including, but not limited
22 to, the insurer's subsequent cancellation or modification of
23 the insured's or policyholder's contract, or the insured's or
24 policyholder's eligibility. Nothing in this Section shall
25 require the insurer to cover a treatment when the
26 authorization was granted based on a material

1 misrepresentation by the insured, the policyholder, or the
2 provider. Nothing in this Section shall require Medicaid
3 managed care organizations to pay for services if the
4 individual was not eligible for Medicaid at the time the
5 service was rendered. Nothing in this Section shall require an
6 insurer to pay for services if the individual was not the
7 insurer's enrollee at the time services were rendered. As used
8 in this paragraph, "material" means a fact or situation that
9 is not merely technical in nature and results in or could
10 result in a substantial change in the situation.

11 (j) An insurer shall not limit benefits or coverage for
12 medically necessary services on the basis that those services
13 should be or could be covered by a public entitlement program,
14 including, but not limited to, special education or an
15 individualized education program, Medicaid, Medicare,
16 Supplemental Security Income, or Social Security Disability
17 Insurance, and shall not include or enforce a contract term
18 that excludes otherwise covered benefits on the basis that
19 those services should be or could be covered by a public
20 entitlement program. Nothing in this subsection shall be
21 construed to require an insurer to cover benefits that have
22 been authorized and provided for a covered person by a public
23 entitlement program. Medicaid managed care organizations are
24 not subject to this subsection.

25 (k) An insurer shall base any medical necessity
26 determination or the utilization review criteria that the

1 insurer, and any entity acting on the insurer's behalf,
2 applies to determine the medical necessity of health care
3 services and benefits for the diagnosis, prevention, and
4 treatment of mental, emotional, nervous, or substance use
5 disorders or conditions on current generally accepted
6 standards of mental, emotional, nervous, or substance use
7 disorder or condition care. All denials and appeals shall be
8 reviewed by a professional with experience or expertise
9 comparable to the provider requesting the authorization.

10 (1) In conducting utilization review of all covered health
11 care services for the diagnosis, prevention, and treatment of
12 mental, emotional, and nervous disorders or conditions, an
13 insurer shall apply the criteria and guidelines set forth in
14 the most recent version of the treatment criteria developed by
15 an unaffiliated nonprofit professional association for the
16 relevant clinical specialty or, for Medicaid managed care
17 organizations, criteria and guidelines determined by the
18 Department of Healthcare and Family Services that are
19 consistent with generally accepted standards of mental,
20 emotional, nervous or substance use disorder or condition
21 care. Pursuant to subsection (b), in conducting utilization
22 review of all covered services and benefits for the diagnosis,
23 prevention, and treatment of substance use disorders an
24 insurer shall use the most recent edition of the patient
25 placement criteria established by the American Society of
26 Addiction Medicine.

1 (m) In conducting utilization review relating to level of
2 care placement, continued stay, transfer, discharge, or any
3 other patient care decisions that are within the scope of the
4 sources specified in subsection (l), an insurer shall not
5 apply different, additional, conflicting, or more restrictive
6 utilization review criteria than the criteria set forth in
7 those sources. For all level of care placement decisions, the
8 insurer shall authorize placement at the level of care
9 consistent with the assessment of the insured using the
10 relevant patient placement criteria as specified in subsection
11 (l). If that level of placement is not available, the insurer
12 shall authorize the next higher level of care. In the event of
13 disagreement, the insurer shall provide full detail of its
14 assessment using the relevant criteria as specified in
15 subsection (l) to the provider of the service and the patient.

16 If an insurer purchases or licenses utilization review
17 criteria pursuant to this subsection, the insurer shall verify
18 and document before use that the criteria were developed in
19 accordance with subsection (k).

20 (n) In conducting utilization review that is outside the
21 scope of the criteria as specified in subsection (l) or
22 relates to the advancements in technology or in the types or
23 levels of care that are not addressed in the most recent
24 versions of the sources specified in subsection (l), an
25 insurer shall conduct utilization review in accordance with
26 subsection (k).

1 (o) This Section does not in any way limit the rights of a
2 patient under the Medical Patient Rights Act.

3 (p) This Section does not in any way limit early and
4 periodic screening, diagnostic, and treatment benefits as
5 defined under 42 U.S.C. 1396d(r).

6 (q) To ensure the proper use of the criteria described in
7 subsection (l), every insurer shall do all of the following:

8 (1) Educate the insurer's staff, including any third
9 parties contracted with the insurer to review claims,
10 conduct utilization reviews, or make medical necessity
11 determinations about the utilization review criteria.

12 (2) Make the educational program available to other
13 stakeholders, including the insurer's participating or
14 contracted providers and potential participants,
15 beneficiaries, or covered lives. The education program
16 must be provided at least once a year, in-person or
17 digitally, or recordings of the education program must be
18 made available to the aforementioned stakeholders.

19 (3) Provide, at no cost, the utilization review
20 criteria and any training material or resources to
21 providers and insured patients upon request. For
22 utilization review criteria not concerning level of care
23 placement, continued stay, transfer, discharge, or other
24 patient care decisions used by the insurer pursuant to
25 subsection (m), the insurer may place the criteria on a
26 secure, password-protected website so long as the access

1 requirements of the website do not unreasonably restrict
2 access to insureds or their providers. No restrictions
3 shall be placed upon the insured's or treating provider's
4 access right to utilization review criteria obtained under
5 this paragraph at any point in time, including before an
6 initial request for authorization.

7 (4) Track, identify, and analyze how the utilization
8 review criteria are used to certify care, deny care, and
9 support the appeals process.

10 (5) Conduct interrater reliability testing to ensure
11 consistency in utilization review decision making that
12 covers how medical necessity decisions are made; this
13 assessment shall cover all aspects of utilization review
14 as defined in subsection (h).

15 (6) Run interrater reliability reports about how the
16 clinical guidelines are used in conjunction with the
17 utilization review process and parity compliance
18 activities.

19 (7) Achieve interrater reliability pass rates of at
20 least 90% and, if this threshold is not met, immediately
21 provide for the remediation of poor interrater reliability
22 and interrater reliability testing for all new staff
23 before they can conduct utilization review without
24 supervision.

25 (8) Maintain documentation of interrater reliability
26 testing and the remediation actions taken for those with

1 pass rates lower than 90% and submit to the Department of
2 Insurance or, in the case of Medicaid managed care
3 organizations, the Department of Healthcare and Family
4 Services the testing results and a summary of remedial
5 actions as part of parity compliance reporting set forth
6 in subsection (k) of Section 370c.1.

7 (r) This Section applies to all health care services and
8 benefits for the diagnosis, prevention, and treatment of
9 mental, emotional, nervous, or substance use disorders or
10 conditions covered by an insurance policy, including
11 prescription drugs.

12 (s) This Section applies to an insurer that amends,
13 delivers, issues, or renews a group or individual policy of
14 accident and health insurance or a qualified health plan
15 offered through the health insurance marketplace in this State
16 providing coverage for hospital or medical treatment and
17 conducts utilization review as defined in this Section,
18 including Medicaid managed care organizations, and any entity
19 or contracting provider that performs utilization review or
20 utilization management functions on an insurer's behalf.

21 (t) If the Director determines that an insurer has
22 violated this Section, the Director may, after appropriate
23 notice and opportunity for hearing, by order, assess a civil
24 penalty between \$1,000 and \$5,000 for each violation. Moneys
25 collected from penalties shall be deposited into the Parity
26 Advancement Fund established in subsection (i) of Section

1 370c.1.

2 (u) An insurer shall not adopt, impose, or enforce terms
3 in its policies or provider agreements, in writing or in
4 operation, that undermine, alter, or conflict with the
5 requirements of this Section.

6 (v) The provisions of this Section are severable. If any
7 provision of this Section or its application is held invalid,
8 that invalidity shall not affect other provisions or
9 applications that can be given effect without the invalid
10 provision or application.

11 (w) Beginning January 1, 2026, coverage for medically
12 necessary treatment of mental, emotional, or nervous disorders
13 or conditions for inpatient mental health treatment at
14 participating hospitals shall comply with the following
15 requirements:

16 (1) ~~No subject to paragraphs (2) and (3) of this~~
17 ~~subsection, no~~ policy shall require prior authorization
18 for outpatient or partial hospitalization services for
19 treatment of mental, emotional, or nervous disorders or
20 conditions provided by a physician licensed to practice
21 medicine in all branches, a licensed clinical
22 psychologist, a licensed clinical social worker, a
23 licensed clinical professional counselor, a licensed
24 marriage and family therapist, or a licensed
25 speech-language pathologist. Such coverage may be subject
26 to concurrent and retrospective review consistent with the

1 utilization review provisions in subsections (h) through
2 (n). No such coverage shall be subject to concurrent
3 review prior to the applicable notification deadline.
4 Nothing in this paragraph (1) supersedes a health
5 maintenance organization's referral requirement for
6 services from nonparticipating providers. The treatment
7 provider or facility shall notify the insurer of the
8 initiation of treatment. Notification shall occur as
9 follows: ~~admission for such treatment at any participating~~
10 hospital.

11 (A) For an insurer that is not a Medicaid managed
12 care organization, the treatment provider or facility
13 shall give notification of the initiation of
14 outpatient treatment of the covered person within 2
15 business days. For Medicaid managed care
16 organizations, the treatment provider or facility
17 shall give notification of the initiation of
18 outpatient treatment of the covered person within 24
19 hours. If the Medicaid managed care organization is
20 not capable of accepting the notification in
21 accordance with the contractual protocol during the
22 24-hour period following initiation, the treatment
23 provider or facility shall have one additional
24 business day to provide the notification to the
25 appropriate Medicaid managed care organization.

26 (B) For an insurer that is not a Medicaid managed

1 care organization, the treatment provider or facility
2 shall give notification of the initiation of partial
3 hospitalization program treatment of the covered
4 person within 48 hours. For Medicaid managed care
5 organizations, the treatment provider or facility
6 shall give notification of the initiation of partial
7 hospitalization treatment of the covered person within
8 24 hours. If the Medicaid managed care organization is
9 not capable of accepting the notification in
10 accordance with the contractual protocol during the
11 24-hour period following admission, the treatment
12 provider or facility shall have one additional
13 business day to provide the notification to the
14 appropriate Medicaid managed care organization.

15 (2) No policy shall require prior authorization for
16 inpatient treatment at a hospital for mental, emotional,
17 or nervous disorders or conditions at a participating
18 provider. Additionally, no such coverage shall ~~Coverage~~
19 ~~provided under this subsection also shall not~~ be subject
20 to concurrent review for the first 72 hours after
21 admission, provided that the provider ~~hospital~~ must notify
22 the insurer of both the admission and the initial
23 treatment plan within 48 hours of admission. A discharge
24 plan must be fully developed and continuity services
25 prepared to meet the patient's needs and the patient's
26 community preference upon release. ~~Nothing in this~~

1 ~~paragraph supersedes a health maintenance organization's~~
2 ~~referral requirement for services from nonparticipating~~
3 ~~providers upon a patient's discharge from a hospital~~
4 Recommended level of care placements identified in the
5 discharge plan shall comply with generally accepted
6 standards of care, as defined in subsection (h).

7 (A) If the provider satisfies the conditions of
8 paragraph (2), then the insurer shall approve coverage
9 of the recommended level of care, if applicable, upon
10 discharge subject to concurrent review.

11 (B) Nothing in this paragraph supersedes a health
12 maintenance organization's referral requirement for
13 services from nonparticipating providers upon a
14 patient's discharge from a hospital or facility.

15 (C) Concurrent review for such coverage must be
16 consistent with the utilization review provisions in
17 subsections (h) through (n).

18 (D) In this subsection, residential treatment that
19 is not otherwise identified in the discharge plan is
20 not inpatient hospitalization.

21 (3) Treatment provided under this subsection may be
22 reviewed retrospectively. If coverage is denied
23 retrospectively, neither the insurer nor the participating
24 provider ~~hospital~~ shall bill, and the insured shall not be
25 liable, for any treatment under this subsection through
26 the date the adverse determination is issued, other than

1 any copayment, coinsurance, or deductible for the stay
2 through that date as applicable under the policy. Coverage
3 shall not be retrospectively denied for the first 72 hours
4 of admission to inpatient hospitalization for treatment of
5 mental, emotional, or nervous disorders or conditions, or
6 before the applicable deadline under paragraph (1) of this
7 subsection for outpatient treatment or partial
8 hospitalization programs, ~~treatment~~ at a participating
9 provider ~~hospital~~ except:

10 (A) upon reasonable determination that the
11 inpatient mental health treatment was not provided;

12 (B) upon determination that the patient receiving
13 the treatment was not an insured, enrollee, or
14 beneficiary under the policy;

15 (C) upon material misrepresentation by the patient
16 or health care provider. In this item (C), "material"
17 means a fact or situation that is not merely technical
18 in nature and results or could result in a substantial
19 change in the situation; ~~or~~

20 (D) upon determination that a service was excluded
21 under the terms of coverage. In that case, the
22 limitation to billing for a copayment, coinsurance, or
23 deductible shall not apply; ~~or~~

24 (E) upon determination that a service was not
25 medically necessary consistent with subsections (h)
26 through (n); or

1 (F) upon determination that the patient did not
2 consent to the treatment and that there was no court
3 order mandating the treatment.

4 ~~(4)~~ Nothing in this subsection shall be construed to
5 require a policy to cover any health care service excluded
6 under the terms of coverage.

7 This subsection does not apply to coverage for any
8 prescription or over-the-counter drug.

9 Nothing in this subsection shall be construed to
10 require the medical assistance program to reimburse for
11 services not covered by the medical assistance program as
12 authorized by the Illinois Public Aid Code or the
13 Children's Health Insurance Program Act.

14 (x) Notwithstanding any provision of this Section, nothing
15 shall require the medical assistance program under Article V
16 of the Illinois Public Aid Code or the Children's Health
17 Insurance Program Act to violate any applicable federal laws,
18 regulations, or grant requirements, including requirements for
19 utilization management, or any State or federal consent
20 decrees. Nothing in subsection (g) or ~~subsection~~ (w) shall
21 prevent the Department of Healthcare and Family Services from
22 requiring a health care provider to use specified level of
23 care, admission, continued stay, or discharge criteria,
24 including, but not limited to, those under Section 5-5.23 of
25 the Illinois Public Aid Code, as long as the Department of
26 Healthcare and Family Services, subject to applicable federal

1 laws, regulations, or grant requirements, including
2 requirements for utilization management, does not require a
3 health care provider to seek prior authorization or concurrent
4 review from the Department of Healthcare and Family Services,
5 a Medicaid managed care organization, or a utilization review
6 organization under the circumstances expressly prohibited by
7 subsections (g) and ~~subsection~~ (w). Nothing in this Section
8 prohibits a health plan, including a Medicaid managed care
9 organization, from conducting reviews for medical necessity,
10 clinical appropriateness, safety, fraud, waste, or abuse and
11 reporting suspected fraud, waste, or abuse according to State
12 and federal requirements. Nothing in this Section limits the
13 authority of the Department of Healthcare and Family Services
14 or another State agency, or a Medicaid managed care
15 organization on the State agency's behalf, to (i) implement or
16 require programs, services, screenings, assessments, tools, or
17 reviews to comply with applicable federal law, federal
18 regulation, federal grant requirements, any State or federal
19 consent decrees or court orders, or any applicable case law,
20 such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii)
21 administer or require programs, services, screenings,
22 assessments, tools, or reviews established under State or
23 federal laws, rules, or regulations in compliance with State
24 or federal laws, rules, or regulations, including, but not
25 limited to, the Children's Mental Health Act and the Mental
26 Health and Developmental Disabilities Administrative Act.

1 (y) (Blank). ~~Children's Mental Health. Nothing in this~~
2 ~~Section shall suspend the screening and assessment~~
3 ~~requirements for mental health services for children~~
4 ~~participating in the State's medical assistance program as~~
5 ~~required in Section 5.23 of the Illinois Public Aid Code.~~

6 (Source: P.A. 102-558, eff. 8-20-21; 102-579, eff. 1-1-22;
7 102-813, eff. 5-13-22; 103-426, eff. 8-4-23; 103-650, eff.
8 1-1-25; 103-1040, eff. 8-9-24; revised 11-26-24.)

9 Section 10. The Network Adequacy and Transparency Act is
10 amended by changing Section 10 as follows:

11 (215 ILCS 124/10)

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

13 Sec. 10. Network adequacy.

14 (a) Before issuing, delivering, or renewing a network
15 plan, an issuer providing a network plan shall file a
16 description of all of the following with the Director:

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

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

24 (3) The written policies and procedures on how the

1 network plan will provide 24-hour, 7-day per week access
2 to network-affiliated primary care, emergency services,
3 and women's principal health care providers.

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

12 (b) Before issuing, delivering, or renewing a network
13 plan, an issuer must file for review a description of the
14 services to be offered through a network plan. The description
15 shall include all of the following:

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

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

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

25 (4) An Internet website and toll-free telephone number
26 for beneficiaries and prospective beneficiaries to access

1 current and accurate lists of preferred providers in each
2 plan, additional information about the plan, as well as
3 any other information required by Department rule.

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

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

10 (B) the ratio of physicians and other providers to
11 beneficiaries, by specialty and including primary care
12 physicians and facility-based physicians when
13 applicable under the contract, necessary to meet the
14 health care needs and service demands of the currently
15 enrolled population;

16 (C) the travel and distance standards for plan
17 beneficiaries in county service areas; and

18 (D) a description of how the use of telemedicine,
19 telehealth, or mobile care services may be used to
20 partially meet the network adequacy standards, if
21 applicable.

22 (6) A provision ensuring that whenever a beneficiary
23 has made a good faith effort, as evidenced by accessing
24 the provider directory, calling the network plan, and
25 calling the provider, to utilize preferred providers for a
26 covered service and it is determined the insurer does not

1 have the appropriate preferred providers due to
2 insufficient number, type, unreasonable travel distance or
3 delay, or preferred providers refusing to provide a
4 covered service because it is contrary to the conscience
5 of the preferred providers, as protected by the Health
6 Care Right of Conscience Act, the issuer shall give the
7 beneficiary a network exception and shall ensure, directly
8 or indirectly, by terms contained in the payer contract,
9 that the beneficiary will be provided the covered service
10 at no greater cost to the beneficiary than if the service
11 had been provided by a preferred provider. This paragraph
12 (6) does not apply to: (A) a beneficiary who willfully
13 chooses to access a non-preferred provider for health care
14 services available through the panel of preferred
15 providers, or (B) a beneficiary enrolled in a health
16 maintenance organization, except that the health
17 maintenance organization must notify the beneficiary when
18 a referral has been granted as a network exception based
19 on any preferred provider access deficiency described in
20 this paragraph or under the circumstances applicable in
21 paragraph (3) of subsection (d-5). In these circumstances,
22 the contractual requirements for non-preferred provider
23 reimbursements shall apply unless Section 356z.3a of the
24 Illinois Insurance Code requires otherwise. In no event
25 shall a beneficiary who receives care at a participating
26 health care facility be required to search for

1 participating providers under the circumstances described
2 in subsection (b) or (b-5) of Section 356z.3a of the
3 Illinois Insurance Code except under the circumstances
4 described in paragraph (2) of subsection (b-5).

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

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

22 (9) For a network plan to be offered through the
23 Exchange in the individual or small group market, as well
24 as any off-Exchange mirror of such a network plan,
25 evidence that the network plan includes essential
26 community providers in accordance with rules established

1 by the Exchange that will operate in this State for the
2 applicable plan year.

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

6 (1) The minimum ratio of physicians or other providers
7 to plan beneficiaries shall be established 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, except to the extent provided under federal law
14 for stand-alone dental plans. The Department shall
15 consider establishing ratios for the following physicians
16 or other providers:

- 17 (A) Primary Care;
- 18 (B) Pediatrics;
- 19 (C) Cardiology;
- 20 (D) Gastroenterology;
- 21 (E) General Surgery;
- 22 (F) Neurology;
- 23 (G) OB/GYN;
- 24 (H) Oncology/Radiation;
- 25 (I) Ophthalmology;
- 26 (J) Urology;

1 (K) Behavioral Health;
2 (L) Allergy/Immunology;
3 (M) Chiropractic;
4 (N) Dermatology;
5 (O) Endocrinology;
6 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
7 (Q) Infectious Disease;
8 (R) Nephrology;
9 (S) Neurosurgery;
10 (T) Orthopedic Surgery;
11 (U) Physiatry/Rehabilitative;
12 (V) Plastic Surgery;
13 (W) Pulmonary;
14 (X) Rheumatology;
15 (Y) Anesthesiology;
16 (Z) Pain Medicine;
17 (AA) Pediatric Specialty Services;
18 (BB) Outpatient Dialysis; and
19 (CC) HIV.

20 (2) The Director shall establish a process for the
21 review of the adequacy of these standards, along with an
22 assessment of additional specialties to be included in the
23 list under this subsection (c).

24 (3) Notwithstanding any other law or rule, the minimum
25 ratio for each provider type shall be no less than any such
26 ratio established for qualified health plans in

1 Federally-Facilitated Exchanges by federal law or by the
2 federal Centers for Medicare and Medicaid Services, even
3 if the network plan is issued in the large group market or
4 is otherwise not issued through an exchange. Federal
5 standards for stand-alone dental plans shall only apply to
6 such network plans. In the absence of an applicable
7 Department rule, the federal standards shall apply for the
8 time period specified in the federal law, regulation, or
9 guidance. If the Centers for Medicare and Medicaid
10 Services establish standards that are more stringent than
11 the standards in effect under any Department rule, the
12 Department may amend its rules to conform to the more
13 stringent federal standards.

14 (d) The network plan shall demonstrate to the Director
15 maximum travel and distance standards and appointment wait
16 time standards for plan beneficiaries, which shall be
17 established by the Department in consultation with the
18 Department of Public Health based upon the guidance from the
19 federal Centers for Medicare and Medicaid Services. These
20 standards shall consist of the maximum minutes or miles to be
21 traveled by a plan beneficiary for each county type, such as
22 large counties, metro counties, or rural counties as defined
23 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 Notwithstanding any other law or Department rule, the
6 maximum travel time and distance standards and appointment
7 wait time standards shall be no greater than any such
8 standards established for qualified health plans in
9 Federally-Facilitated Exchanges by federal law or by the
10 federal Centers for Medicare and Medicaid Services, even if
11 the network plan is issued in the large group market or is
12 otherwise not issued through an exchange. Federal standards
13 for stand-alone dental plans shall only apply to such network
14 plans. In the absence of an applicable Department rule, the
15 federal standards shall apply for the time period specified in
16 the federal law, regulation, or guidance. If the Centers for
17 Medicare and Medicaid Services establish standards that are
18 more stringent than the standards in effect under any
19 Department rule, the Department may amend its rules to conform
20 to the more stringent federal standards.

21 If the federal area designations for the maximum time or
22 distance or appointment wait time standards required are
23 changed by the most recent Letter to Issuers in the
24 Federally-facilitated Marketplaces, the Department shall post
25 on its website notice of such changes and may amend its rules
26 to conform to those designations if the Director deems

1 appropriate.

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

25 (A) For beneficiaries residing in the metropolitan
26 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,

1 network adequacy standards for timely and proximate access
2 to treatment for mental, emotional, nervous, or substance
3 use disorders or conditions means a beneficiary shall not
4 have to travel longer than 30 minutes or 30 miles from the
5 beneficiary's residence to receive outpatient treatment
6 for mental, emotional, nervous, or substance use disorders
7 or conditions. Beneficiaries shall not be required to wait
8 longer than 10 business days between requesting an initial
9 appointment and being seen by the facility or provider of
10 mental, emotional, nervous, or substance use disorders or
11 conditions for outpatient treatment or to wait longer than
12 20 business days between requesting a repeat or follow-up
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; however, subject to
16 the protections of paragraph (3) of this subsection, a
17 network plan shall not be held responsible if the
18 beneficiary or provider voluntarily chooses to schedule an
19 appointment outside of these required time frames.

20 (B) For beneficiaries residing in Illinois counties
21 other than those counties listed in subparagraph (A) of
22 this paragraph, network adequacy standards for timely and
23 proximate access to treatment for mental, emotional,
24 nervous, or substance use disorders or conditions means a
25 beneficiary shall not have to travel longer than 60
26 minutes or 60 miles from the beneficiary's residence to

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

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

24 (3) If there is no in-network facility or provider
25 available for a beneficiary to receive timely and proximate
26 access to treatment for mental, emotional, nervous, or

1 substance use disorders or conditions in accordance with the
2 network adequacy standards outlined in this subsection, the
3 issuer shall provide necessary exceptions to its network to
4 ensure admission and treatment with a provider or at a
5 treatment facility in accordance with the network adequacy
6 standards in this subsection at the in-network benefit level.

7 (A) For plan or policy years beginning on or after
8 January 1, 2026, the issuer also shall provide reasonable
9 reimbursement to a beneficiary who has received an
10 exception as outlined in this paragraph (3) for costs
11 including food, lodging, and travel.

12 (i) Reimbursement for food and lodging shall be at
13 the prevailing federal per diem rates then in effect,
14 as set by the United States General Services
15 Administration. Reimbursement for travel by vehicle
16 shall be reimbursed at the current Internal Revenue
17 Service mileage standard for miles driven for
18 transportation or travel expenses.

19 (ii) At the time an issuer grants an exception
20 under this paragraph (3), the issuer shall give
21 written notification to the beneficiary of potential
22 eligibility for reimbursement under this subparagraph
23 (A) and instructions on how to file a claim for such
24 reimbursement, including a link to the claim form on
25 the issuer's public website and a phone number for a
26 beneficiary to request that the issuer send a hard

1 copy of the claim form by postal mail. The Department
2 shall create the template for the reimbursement
3 notification form, which issuers shall fill in and
4 post on their public website.

5 (iii) An issuer may require a beneficiary to
6 submit a claim for food, travel, or lodging
7 reimbursement within 60 days of the last date of the
8 health care service for which travel was undertaken,
9 and the beneficiary may appeal any denial of
10 reimbursement claims.

11 (iv) An issuer may deny reimbursement for food,
12 lodging, and travel if the provider's site of care is
13 neither within this State nor within 100 miles of the
14 beneficiary's residence unless, after a good faith
15 effort, no provider can be found who is available
16 within those parameters to provide the medically
17 necessary health care service within 10 business days
18 after a request for appointment.

19 (B) Notwithstanding any other provision of this
20 Section to the contrary, subparagraph (A) of this
21 paragraph (3) does not apply to policies issued or
22 delivered in this State that provide medical assistance
23 under the Illinois Public Aid Code or the Children's
24 Health Insurance Program Act.

25 (4) If the federal Centers for Medicare and Medicaid
26 Services establishes or law requires more stringent standards

1 for qualified health plans in the Federally-Facilitated
2 Exchanges, the federal standards shall control for all network
3 plans for the time period specified in the federal law,
4 regulation, or guidance, even if the network plan is issued in
5 the large group market, is issued through a different type of
6 Exchange, or is otherwise not issued through an Exchange.

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

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

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

22 (1) if no providers or facilities meet the specific
23 time and distance standard in a specific service area and
24 the issuer (i) discloses information on the distance and
25 travel time points that beneficiaries would have to travel
26 beyond the required criterion to reach the next closest

1 contracted provider outside of the service area and (ii)
2 provides contact information, including names, addresses,
3 and phone numbers for the next closest contracted provider
4 or facility;

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

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

14 (h) Issuers are required to report to the Director any
15 material change to an approved network plan within 15 business
16 days after the change occurs and any change that would result
17 in failure to meet the requirements of this Act. The issuer
18 shall submit a revised version of the portions of the network
19 adequacy filing affected by the material change, as determined
20 by the Director by rule, and the issuer shall attach versions
21 with the changes indicated for each document that was revised
22 from the previous version of the filing. Upon notice from the
23 issuer, the Director shall reevaluate the network plan's
24 compliance with the network adequacy and transparency
25 standards of this Act. For every day past 15 business days that
26 the issuer fails to submit a revised network adequacy filing

1 to the Director, the Director may order a fine of \$5,000 per
2 day.

3 (i) If a network plan is inadequate under this Act with
4 respect to a provider type in a county, and if the network plan
5 does not have an approved exception for that provider type in
6 that county pursuant to subsection (g), an issuer shall cover
7 out-of-network claims for covered health care services
8 received from that provider type within that county at the
9 in-network benefit level and shall retroactively adjudicate
10 and reimburse beneficiaries to achieve that objective if their
11 claims were processed at the out-of-network level contrary to
12 this subsection. Nothing in this subsection shall be construed
13 to supersede Section 356z.3a of the Illinois Insurance Code.

14 (j) If the Director determines that a network is
15 inadequate in any county and no exception has been granted
16 under subsection (g) and the issuer does not have a process in
17 place to comply with subsection (d-5), the Director may
18 prohibit the network plan from being issued or renewed within
19 that county until the Director determines that the network is
20 adequate apart from processes and exceptions described in
21 subsections (d-5) and (g). Nothing in this subsection shall be
22 construed to terminate any beneficiary's health insurance
23 coverage under a network plan before the expiration of the
24 beneficiary's policy period if the Director makes a
25 determination under this subsection after the issuance or
26 renewal of the beneficiary's policy or certificate because of

1 a material change. Policies or certificates issued or renewed
2 in violation of this subsection may subject the issuer to a
3 civil penalty of \$5,000 per policy.

4 (k) For the Department to enforce any new or modified
5 federal standard before the Department adopts the standard by
6 rule, the Department must, no later than May 15 before the
7 start of the plan year, give public notice to the affected
8 health insurance issuers through a bulletin.

9 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
10 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

11 (Text of Section from P.A. 103-656)

12 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

26 (5) A description of how health care services to be

1 rendered under the network plan are reasonably accessible
2 and available to beneficiaries. The description shall
3 address all of the following:

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

6 (B) the ratio of physicians and other providers to
7 beneficiaries, by specialty and including primary care
8 physicians and facility-based physicians when
9 applicable under the contract, necessary to meet the
10 health care needs and service demands of the currently
11 enrolled population;

12 (C) the travel and distance standards for plan
13 beneficiaries in county service areas; and

14 (D) a description of how the use of telemedicine,
15 telehealth, or mobile care services may be used to
16 partially meet the network adequacy standards, if
17 applicable.

18 (6) A provision ensuring that whenever a beneficiary
19 has made a good faith effort, as evidenced by accessing
20 the provider directory, calling the network plan, and
21 calling the provider, to utilize preferred providers for a
22 covered service and it is determined the insurer does not
23 have the appropriate preferred providers due to
24 insufficient number, type, unreasonable travel distance or
25 delay, or preferred providers refusing to provide a
26 covered service because it is contrary to the conscience

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

1 (7) A provision that the beneficiary shall receive
2 emergency care coverage such that payment for this
3 coverage is not dependent upon whether the emergency
4 services are performed by a preferred or non-preferred
5 provider and the coverage shall be at the same benefit
6 level as if the service or treatment had been rendered by a
7 preferred provider. For purposes of this paragraph (7),
8 "the same benefit level" means that the beneficiary is
9 provided the covered service at no greater cost to the
10 beneficiary than if the service had been provided by a
11 preferred provider. This provision shall be consistent
12 with Section 356z.3a of the Illinois Insurance Code.

13 (8) A limitation that complies with subsections (d)
14 and (e) of Section 55 of the Prior Authorization Reform
15 Act.

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

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

1 ratios for the following physicians or other providers:

2 (A) Primary Care;

3 (B) Pediatrics;

4 (C) Cardiology;

5 (D) Gastroenterology;

6 (E) General Surgery;

7 (F) Neurology;

8 (G) OB/GYN;

9 (H) Oncology/Radiation;

10 (I) Ophthalmology;

11 (J) Urology;

12 (K) Behavioral Health;

13 (L) Allergy/Immunology;

14 (M) Chiropractic;

15 (N) Dermatology;

16 (O) Endocrinology;

17 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

18 (Q) Infectious Disease;

19 (R) Nephrology;

20 (S) Neurosurgery;

21 (T) Orthopedic Surgery;

22 (U) Physiatry/Rehabilitative;

23 (V) Plastic Surgery;

24 (W) Pulmonary;

25 (X) Rheumatology;

26 (Y) Anesthesiology;

- 1 (Z) Pain Medicine;
2 (AA) Pediatric Specialty Services;
3 (BB) Outpatient Dialysis; and
4 (CC) HIV.

5 (2) The Director shall establish a process for the
6 review of the adequacy of these standards, along with an
7 assessment of additional specialties to be included in the
8 list under this subsection (c).

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 (d-5) (1) Every insurer shall ensure that beneficiaries
26 have timely and proximate access to treatment for mental,

1 emotional, nervous, or substance use disorders or conditions
2 in accordance with the provisions of paragraph (4) of
3 subsection (a) of Section 370c of the Illinois Insurance Code.
4 Insurers shall use a comparable process, strategy, evidentiary
5 standard, and other factors in the development and application
6 of the network adequacy standards for timely and proximate
7 access to treatment for mental, emotional, nervous, or
8 substance use disorders or conditions and those for the access
9 to treatment for medical and surgical conditions. As such, the
10 network adequacy standards for timely and proximate access
11 shall equally be applied to treatment facilities and providers
12 for mental, emotional, nervous, or substance use disorders or
13 conditions and specialists providing medical or surgical
14 benefits pursuant to the parity requirements of Section 370c.1
15 of the Illinois Insurance Code and the federal Paul Wellstone
16 and Pete Domenici Mental Health Parity and Addiction Equity
17 Act of 2008. Notwithstanding the foregoing, the network
18 adequacy standards for timely and proximate access to
19 treatment for mental, emotional, nervous, or substance use
20 disorders or conditions shall, at a minimum, satisfy the
21 following requirements:

22 (A) For beneficiaries residing in the metropolitan
23 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
24 network adequacy standards for timely and proximate access
25 to treatment for mental, emotional, nervous, or substance
26 use disorders or conditions means a beneficiary shall not

1 have to travel longer than 30 minutes or 30 miles from the
2 beneficiary's residence to receive outpatient treatment
3 for mental, emotional, nervous, or substance use disorders
4 or conditions. Beneficiaries shall not be required to wait
5 longer than 10 business days between requesting an initial
6 appointment and being seen by the facility or provider of
7 mental, emotional, nervous, or substance use disorders or
8 conditions for outpatient treatment or to wait longer than
9 20 business days between requesting a repeat or follow-up
10 appointment and being seen by the facility or provider of
11 mental, emotional, nervous, or substance use disorders or
12 conditions for outpatient treatment; however, subject to
13 the protections of paragraph (3) of this subsection, a
14 network plan shall not be held responsible if the
15 beneficiary or provider voluntarily chooses to schedule an
16 appointment outside of these required time frames.

17 (B) For beneficiaries residing in Illinois counties
18 other than those counties listed in subparagraph (A) of
19 this paragraph, network adequacy standards for timely and
20 proximate access to treatment for mental, emotional,
21 nervous, or substance use disorders or conditions means a
22 beneficiary shall not have to travel longer than 60
23 minutes or 60 miles from the beneficiary's residence to
24 receive outpatient treatment for mental, emotional,
25 nervous, or substance use disorders or conditions.
26 Beneficiaries shall not be required to wait longer than 10

1 business days between requesting an initial appointment
2 and being seen by the facility or provider of mental,
3 emotional, nervous, or substance use disorders or
4 conditions for outpatient treatment or to wait longer than
5 20 business days between requesting a repeat or follow-up
6 appointment and being seen by the facility or provider of
7 mental, emotional, nervous, or substance use disorders or
8 conditions for outpatient treatment; however, subject to
9 the protections of paragraph (3) of this subsection, a
10 network plan shall not be held responsible if the
11 beneficiary or provider voluntarily chooses to schedule an
12 appointment outside of these required time frames.

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

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

1 ensure admission and treatment with a provider or at a
2 treatment facility in accordance with the network adequacy
3 standards in this subsection at the in-network benefit level.

4 (A) For plan or policy years beginning on or after
5 January 1, 2026, the issuer also shall provide reasonable
6 reimbursement to a beneficiary who has received an
7 exception as outlined in this paragraph (3) for costs
8 including food, lodging, and travel.

9 (i) Reimbursement for food and lodging shall be at
10 the prevailing federal per diem rates then in effect,
11 as set by the United States General Services
12 Administration. Reimbursement for travel by vehicle
13 shall be reimbursed at the current Internal Revenue
14 Service mileage standard for miles driven for
15 transportation or travel expenses.

16 (ii) At the time an issuer grants an exception
17 under this paragraph (3), the issuer shall give
18 written notification to the beneficiary of potential
19 eligibility for reimbursement under this subparagraph
20 (A) and instructions on how to file a claim for such
21 reimbursement, including a link to the claim form on
22 the issuer's public website and a phone number for a
23 beneficiary to request that the issuer send a hard
24 copy of the claim form by postal mail. The Department
25 shall create the template for the reimbursement
26 notification form, which issuers shall fill in and

1 post on their public website.

2 (iii) An issuer may require a beneficiary to
3 submit a claim for food, travel, or lodging
4 reimbursement within 60 days of the last date of the
5 health care service for which travel was undertaken,
6 and the beneficiary may appeal any denial of
7 reimbursement claims.

8 (iv) An issuer may deny reimbursement for food,
9 lodging, and travel if the provider's site of care is
10 neither within this State nor within 100 miles of the
11 beneficiary's residence unless, after a good faith
12 effort, no provider can be found who is available
13 within those parameters to provide the medically
14 necessary health care service within 10 business days
15 of a request for appointment.

16 (B) Notwithstanding any other provision of this
17 Section to the contrary, subparagraph (A) of this
18 paragraph (3) does not apply to policies issued or
19 delivered in this State that provide medical assistance
20 under the Illinois Public Aid Code or the Children's
21 Health Insurance Program Act.

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

25 (f) The network plan may consider use of other health care
26 service delivery options, such as telemedicine or telehealth,

1 mobile clinics, and centers of excellence, or other ways of
2 delivering care to partially meet the requirements set under
3 this Section.

4 (g) Except for the requirements set forth in subsection
5 (d-5), insurers who are not able to comply with the provider
6 ratios and time and distance standards established by the
7 Department may request an exception to these requirements from
8 the Department. The Department may grant an exception in the
9 following circumstances:

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

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

26 (3) other circumstances deemed appropriate by the

1 Department consistent with the requirements of this Act.

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

9 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
10 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

11 (Text of Section from P.A. 103-718)

12 Sec. 10. Network adequacy.

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

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

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

22 (3) The written policies and procedures on how the
23 network plan will provide 24-hour, 7-day per week access
24 to network-affiliated primary care, emergency services,
25 and obstetrical and gynecological health care

1 professionals.

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

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

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

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

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

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

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

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

7 (B) the ratio of physicians and other providers to
8 beneficiaries, by specialty and including primary care
9 physicians and facility-based physicians when
10 applicable under the contract, necessary to meet the
11 health care needs and service demands of the currently
12 enrolled population;

13 (C) the travel and distance standards for plan
14 beneficiaries in county service areas; and

15 (D) a description of how the use of telemedicine,
16 telehealth, or mobile care services may be used to
17 partially meet the network adequacy standards, if
18 applicable.

19 (6) A provision ensuring that whenever a beneficiary
20 has made a good faith effort, as evidenced by accessing
21 the provider directory, calling the network plan, and
22 calling the provider, to utilize preferred providers for a
23 covered service and it is determined the insurer does not
24 have the appropriate preferred providers due to
25 insufficient number, type, unreasonable travel distance or
26 delay, or preferred providers refusing to provide a

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

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

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

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

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

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

25 (A) Primary Care;

26 (B) Pediatrics;

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

1 (CC) HIV.

2 (2) The Director shall establish a process for the
3 review of the adequacy of these standards, along with an
4 assessment of additional specialties to be included in the
5 list under this subsection (c).

6 (d) The network plan shall demonstrate to the Director
7 maximum travel and distance standards for plan beneficiaries,
8 which shall be established annually by the Department in
9 consultation with the Department of Public Health based upon
10 the guidance from the federal Centers for Medicare and
11 Medicaid Services. These standards shall consist of the
12 maximum minutes or miles to be traveled by a plan beneficiary
13 for each county type, such as large counties, metro counties,
14 or rural counties as defined by Department rule.

15 The maximum travel time and distance standards must
16 include standards for each physician and other provider
17 category listed for which ratios have been established.

18 The Director shall establish a process for the review of
19 the adequacy of these standards along with an assessment of
20 additional specialties to be included in the list under this
21 subsection (d).

22 (d-5)(1) Every insurer shall ensure that beneficiaries
23 have timely and proximate access to treatment for mental,
24 emotional, nervous, or substance use disorders or conditions
25 in accordance with the provisions of paragraph (4) of
26 subsection (a) of Section 370c of the Illinois Insurance Code.

1 Insurers shall use a comparable process, strategy, evidentiary
2 standard, and other factors in the development and application
3 of the network adequacy standards for timely and proximate
4 access to treatment for mental, emotional, nervous, or
5 substance use disorders or conditions and those for the access
6 to treatment for medical and surgical conditions. As such, the
7 network adequacy standards for timely and proximate access
8 shall equally be applied to treatment facilities and providers
9 for mental, emotional, nervous, or substance use disorders or
10 conditions and specialists providing medical or surgical
11 benefits pursuant to the parity requirements of Section 370c.1
12 of the Illinois Insurance Code and the federal Paul Wellstone
13 and Pete Domenici Mental Health Parity and Addiction Equity
14 Act of 2008. Notwithstanding the foregoing, the network
15 adequacy standards for timely and proximate access to
16 treatment for mental, emotional, nervous, or substance use
17 disorders or conditions shall, at a minimum, satisfy the
18 following requirements:

19 (A) For beneficiaries residing in the metropolitan
20 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
21 network adequacy standards for timely and proximate access
22 to treatment for mental, emotional, nervous, or substance
23 use disorders or conditions means a beneficiary shall not
24 have to travel longer than 30 minutes or 30 miles from the
25 beneficiary's residence to receive outpatient treatment
26 for mental, emotional, nervous, or substance use disorders

1 or conditions. Beneficiaries shall not be required to wait
2 longer than 10 business days between requesting an initial
3 appointment and being seen by the facility or provider of
4 mental, emotional, nervous, or substance use disorders or
5 conditions for outpatient treatment or to wait longer than
6 20 business days between requesting a repeat or follow-up
7 appointment and being seen by the facility or provider of
8 mental, emotional, nervous, or substance use disorders or
9 conditions for outpatient treatment; however, subject to
10 the protections of paragraph (3) of this subsection, a
11 network plan shall not be held responsible if the
12 beneficiary or provider voluntarily chooses to schedule an
13 appointment outside of these required time frames.

14 (B) For beneficiaries residing in Illinois counties
15 other than those counties listed in subparagraph (A) of
16 this paragraph, network adequacy standards for timely and
17 proximate access to treatment for mental, emotional,
18 nervous, or substance use disorders or conditions means a
19 beneficiary shall not have to travel longer than 60
20 minutes or 60 miles from the beneficiary's residence to
21 receive outpatient treatment for mental, emotional,
22 nervous, or substance use disorders or conditions.
23 Beneficiaries shall not be required to wait longer than 10
24 business days between requesting an initial appointment
25 and being seen by the facility or provider of mental,
26 emotional, nervous, or substance use disorders or

1 conditions for outpatient treatment or to wait longer than
2 20 business days between requesting a repeat or follow-up
3 appointment and being seen by the facility or provider of
4 mental, emotional, nervous, or substance use disorders or
5 conditions for outpatient treatment; however, subject to
6 the protections of paragraph (3) of this subsection, a
7 network plan shall not be held responsible if the
8 beneficiary or provider voluntarily chooses to schedule an
9 appointment outside of these required time frames.

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

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

1 (A) For plan or policy years beginning on or after
2 January 1, 2026, the issuer also shall provide reasonable
3 reimbursement to a beneficiary who has received an
4 exception as outlined in this paragraph (3) for costs
5 including food, lodging, and travel.

6 (i) Reimbursement for food and lodging shall be at
7 the prevailing federal per diem rates then in effect,
8 as set by the United States General Services
9 Administration. Reimbursement for travel by vehicle
10 shall be reimbursed at the current Internal Revenue
11 Service mileage standard for miles driven for
12 transportation or travel expenses.

13 (ii) At the time an issuer grants an exception
14 under this paragraph (3), the issuer shall give
15 written notification to the beneficiary of potential
16 eligibility for reimbursement under this subparagraph
17 (A) and instructions on how to file a claim for such
18 reimbursement, including a link to the claim form on
19 the issuer's public website and a phone number for a
20 beneficiary to request that the issuer send a hard
21 copy of the claim form by postal mail. The Department
22 shall create the template for the reimbursement
23 notification form, which issuers shall fill in and
24 post on their public website.

25 (iii) An issuer may require a beneficiary to
26 submit a claim for food, travel, or lodging

1 reimbursement within 60 days of the last date of the
2 health care service for which travel was undertaken,
3 and the beneficiary may appeal any denial of
4 reimbursement claims.

5 (iv) An issuer may deny reimbursement for food,
6 lodging, and travel if the provider's site of care is
7 neither within this State nor within 100 miles of the
8 beneficiary's residence unless, after a good faith
9 effort, no provider can be found who is available
10 within those parameters to provide the medically
11 necessary health care service within 10 business days
12 of a request for appointment.

13 (B) Notwithstanding any other provision of this
14 Section to the contrary, subparagraph (A) of this
15 paragraph (3) does not apply to policies issued or
16 delivered in this State that provide medical assistance
17 under the Illinois Public Aid Code or the Children's
18 Health Insurance Program Act.

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

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

1 (g) Except for the requirements set forth in subsection
2 (d-5), insurers who are not able to comply with the provider
3 ratios and time and distance standards established by the
4 Department may request an exception to these requirements from
5 the Department. The Department may grant an exception in the
6 following circumstances:

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

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

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

25 (h) Insurers are required to report to the Director any
26 material change to an approved network plan within 15 days

1 after the change occurs and any change that would result in
2 failure to meet the requirements of this Act. Upon notice from
3 the insurer, the Director shall reevaluate the network plan's
4 compliance with the network adequacy and transparency
5 standards of this Act.

6 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
7 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

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

9 Sec. 10. Network adequacy.

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

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

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

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

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

1 treatment options or from advocating on behalf of
2 beneficiaries within the utilization review, grievance, or
3 appeals processes established by the insurer in accordance
4 with any rights or remedies available under applicable State
5 or federal law.

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

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

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

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

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

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

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

3 (B) the ratio of physicians and other providers to
4 beneficiaries, by specialty and including primary care
5 physicians and facility-based physicians when
6 applicable under the contract, necessary to meet the
7 health care needs and service demands of the currently
8 enrolled population;

9 (C) the travel and distance standards for plan
10 beneficiaries in county service areas; and

11 (D) a description of how the use of telemedicine,
12 telehealth, or mobile care services may be used to
13 partially meet the network adequacy standards, if
14 applicable.

15 (6) A provision ensuring that whenever a beneficiary
16 has made a good faith effort, as evidenced by accessing
17 the provider directory, calling the network plan, and
18 calling the provider, to utilize preferred providers for a
19 covered service and it is determined the insurer does not
20 have the appropriate preferred providers due to
21 insufficient number, type, unreasonable travel distance or
22 delay, or preferred providers refusing to provide a
23 covered service because it is contrary to the conscience
24 of the preferred providers, as protected by the Health
25 Care Right of Conscience Act, the insurer shall give the
26 beneficiary a network exception and shall ensure, directly

1 or indirectly, by terms contained in the payer contract,
2 that the beneficiary will be provided the covered service
3 at no greater cost to the beneficiary than if the service
4 had been provided by a preferred provider. This paragraph
5 (6) does not apply to: (A) a beneficiary who willfully
6 chooses to access a non-preferred provider for health care
7 services available through the panel of preferred
8 providers, or (B) a beneficiary enrolled in a health
9 maintenance organization, except that the health
10 maintenance organization must notify the beneficiary when
11 a referral has been granted as a network exception based
12 on any preferred provider access deficiency described in
13 this paragraph or under the circumstances applicable in
14 paragraph (3) of subsection (d-5). In these circumstances,
15 the contractual requirements for non-preferred provider
16 reimbursements shall apply unless Section 356z.3a of the
17 Illinois Insurance Code requires otherwise. In no event
18 shall a beneficiary who receives care at a participating
19 health care facility be required to search for
20 participating providers under the circumstances described
21 in subsection (b) or (b-5) of Section 356z.3a of the
22 Illinois Insurance Code except under the circumstances
23 described in paragraph (2) of subsection (b-5).

24 (7) A provision that the beneficiary shall receive
25 emergency care coverage such that payment for this
26 coverage is not dependent upon whether the emergency

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

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

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

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

1 consider establishing ratios for the following physicians
2 or other providers:

3 (A) Primary Care;

4 (B) Pediatrics;

5 (C) Cardiology;

6 (D) Gastroenterology;

7 (E) General Surgery;

8 (F) Neurology;

9 (G) OB/GYN;

10 (H) Oncology/Radiation;

11 (I) Ophthalmology;

12 (J) Urology;

13 (K) Behavioral Health;

14 (L) Allergy/Immunology;

15 (M) Chiropractic;

16 (N) Dermatology;

17 (O) Endocrinology;

18 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

19 (Q) Infectious Disease;

20 (R) Nephrology;

21 (S) Neurosurgery;

22 (T) Orthopedic Surgery;

23 (U) Physiatry/Rehabilitative;

24 (V) Plastic Surgery;

25 (W) Pulmonary;

26 (X) Rheumatology;

- 1 (Y) Anesthesiology;
2 (Z) Pain Medicine;
3 (AA) Pediatric Specialty Services;
4 (BB) Outpatient Dialysis; and
5 (CC) HIV.

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

10 (3) If the federal Centers for Medicare and Medicaid
11 Services establishes minimum provider ratios for
12 stand-alone dental plans in the type of exchange in use in
13 this State for a given plan year, the Department shall
14 enforce those standards for stand-alone dental plans for
15 that plan year.

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 If the federal Centers for Medicare and Medicaid Services
7 establishes appointment wait-time standards for qualified
8 health plans, including stand-alone dental plans, in the type
9 of exchange in use in this State for a given plan year, the
10 Department shall enforce those standards for the same types of
11 qualified health plans for that plan year. If the federal
12 Centers for Medicare and Medicaid Services establishes time
13 and distance standards for stand-alone dental plans in the
14 type of exchange in use in this State for a given plan year,
15 the Department shall enforce those standards for stand-alone
16 dental plans for that plan year.

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

1 to treatment for medical and surgical conditions. As such, the
2 network adequacy standards for timely and proximate access
3 shall equally be applied to treatment facilities and providers
4 for mental, emotional, nervous, or substance use disorders or
5 conditions and specialists providing medical or surgical
6 benefits pursuant to the parity requirements of Section 370c.1
7 of the Illinois Insurance Code and the federal Paul Wellstone
8 and Pete Domenici Mental Health Parity and Addiction Equity
9 Act of 2008. Notwithstanding the foregoing, the network
10 adequacy standards for timely and proximate access to
11 treatment for mental, emotional, nervous, or substance use
12 disorders or conditions shall, at a minimum, satisfy the
13 following requirements:

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

1 20 business days between requesting a repeat or follow-up
2 appointment and being seen by the facility or provider of
3 mental, emotional, nervous, or substance use disorders or
4 conditions for outpatient treatment; however, subject to
5 the protections of paragraph (3) of this subsection, a
6 network plan shall not be held responsible if the
7 beneficiary or provider voluntarily chooses to schedule an
8 appointment outside of these required time frames.

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

1 the protections of paragraph (3) of this subsection, a
2 network plan shall not be held responsible if the
3 beneficiary or provider voluntarily chooses to schedule an
4 appointment outside of these required time frames.

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

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

22 (A) For plan or policy years beginning on or after
23 January 1, 2026, the issuer also shall provide reasonable
24 reimbursement to a beneficiary who has received an
25 exception as outlined in this paragraph (3) for costs
26 including food, lodging, and travel.

1 (i) Reimbursement for food and lodging shall be at
2 the prevailing federal per diem rates then in effect,
3 as set by the United States General Services
4 Administration. Reimbursement for travel by vehicle
5 shall be reimbursed at the current Internal Revenue
6 Service mileage standard for miles driven for
7 transportation or travel expenses.

8 (ii) At the time an issuer grants an exception
9 under this paragraph (3), the issuer shall give
10 written notification to the beneficiary of potential
11 eligibility for reimbursement under this subparagraph
12 (A) and instructions on how to file a claim for such
13 reimbursement, including a link to the claim form on
14 the issuer's public website and a phone number for a
15 beneficiary to request that the issuer send a hard
16 copy of the claim form by postal mail. The Department
17 shall create the template for the reimbursement
18 notification form, which issuers shall fill in and
19 post on their public website.

20 (iii) An issuer may require a beneficiary to
21 submit a claim for food, travel, or lodging
22 reimbursement within 60 days of the last date of the
23 health care service for which travel was undertaken,
24 and the beneficiary may appeal any denial of
25 reimbursement claims.

26 (iv) An issuer may deny reimbursement for food,

1 lodging, and travel if the provider's site of care is
2 neither within this State nor within 100 miles of the
3 beneficiary's residence unless, after a good faith
4 effort, no provider can be found who is available
5 within those parameters to provide the medically
6 necessary health care service within 10 business days
7 of a request for appointment.

8 (B) Notwithstanding any other provision of this
9 Section to the contrary, subparagraph (A) of this
10 paragraph (3) does not apply to policies issued or
11 delivered in this State that provide medical assistance
12 under the Illinois Public Aid Code or the Children's
13 Health Insurance Program Act.

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

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

25 (f) The network plan may consider use of other health care
26 service delivery options, such as telemedicine or telehealth,

1 mobile clinics, and centers of excellence, or other ways of
2 delivering care to partially meet the requirements set under
3 this Section.

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

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

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

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

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

10 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
11 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

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

13 Sec. 10. Network adequacy.

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

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

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

23 (3) The written policies and procedures on how the
24 network plan will provide 24-hour, 7-day per week access
25 to network-affiliated primary care, emergency services,

1 and women's principal health care providers.

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

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

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

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

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

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

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

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

7 (B) the ratio of physicians and other providers to
8 beneficiaries, by specialty and including primary care
9 physicians and facility-based physicians when
10 applicable under the contract, necessary to meet the
11 health care needs and service demands of the currently
12 enrolled population;

13 (C) the travel and distance standards for plan
14 beneficiaries in county service areas; and

15 (D) a description of how the use of telemedicine,
16 telehealth, or mobile care services may be used to
17 partially meet the network adequacy standards, if
18 applicable.

19 (6) A provision ensuring that whenever a beneficiary
20 has made a good faith effort, as evidenced by accessing
21 the provider directory, calling the network plan, and
22 calling the provider, to utilize preferred providers for a
23 covered service and it is determined the insurer does not
24 have the appropriate preferred providers due to
25 insufficient number, type, unreasonable travel distance or
26 delay, or preferred providers refusing to provide a

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

1 described in paragraph (2) of subsection (b-5).

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

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

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

22 (1) The ratio of physicians or other providers to plan
23 beneficiaries shall be established annually by the
24 Department in consultation with the Department of Public
25 Health based upon the guidance from the federal Centers
26 for Medicare and Medicaid Services. The Department shall

1 not establish ratios for vision or dental providers who
2 provide services under dental-specific or vision-specific
3 benefits. The Department shall consider establishing
4 ratios for the following physicians or other providers:

5 (A) Primary Care;

6 (B) Pediatrics;

7 (C) Cardiology;

8 (D) Gastroenterology;

9 (E) General Surgery;

10 (F) Neurology;

11 (G) OB/GYN;

12 (H) Oncology/Radiation;

13 (I) Ophthalmology;

14 (J) Urology;

15 (K) Behavioral Health;

16 (L) Allergy/Immunology;

17 (M) Chiropractic;

18 (N) Dermatology;

19 (O) Endocrinology;

20 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

21 (Q) Infectious Disease;

22 (R) Nephrology;

23 (S) Neurosurgery;

24 (T) Orthopedic Surgery;

25 (U) Physiatry/Rehabilitative;

26 (V) Plastic Surgery;

- 1 (W) Pulmonary;
- 2 (X) Rheumatology;
- 3 (Y) Anesthesiology;
- 4 (Z) Pain Medicine;
- 5 (AA) Pediatric Specialty Services;
- 6 (BB) Outpatient Dialysis; and
- 7 (CC) HIV.

8 (1.5) Beginning January 1, 2026, every insurer shall
9 demonstrate to the Director that each in-network hospital
10 has at least one radiologist, pathologist,
11 anesthesiologist, and emergency room physician as a
12 preferred provider in a network plan. The Department may,
13 by rule, require additional types of hospital-based
14 medical specialists to be included as preferred providers
15 in each in-network hospital in a network plan.

16 (2) The Director shall establish a process for the
17 review of the adequacy of these standards, along with an
18 assessment of additional specialties to be included in the
19 list under this subsection (c).

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

1 for each county type, such as large counties, metro counties,
2 or rural counties as defined 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 (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 at the in-network benefit level.

15 (A) For plan or policy years beginning on or after
16 January 1, 2026, the issuer also shall provide reasonable
17 reimbursement to a beneficiary who has received an
18 exception as outlined in this paragraph (3) for costs
19 including food, lodging, and travel.

20 (i) Reimbursement for food and lodging shall be at
21 the prevailing federal per diem rates then in effect,
22 as set by the United States General Services
23 Administration. Reimbursement for travel by vehicle
24 shall be reimbursed at the current Internal Revenue
25 Service mileage standard for miles driven for
26 transportation or travel expenses.

1 (ii) At the time an issuer grants an exception
2 under this paragraph (3), the issuer shall give
3 written notification to the beneficiary of potential
4 eligibility for reimbursement under this subparagraph
5 (A) and instructions on how to file a claim for such
6 reimbursement, including a link to the claim form on
7 the issuer's public website and a phone number for a
8 beneficiary to request that the issuer send a hard
9 copy of the claim form by postal mail. The Department
10 shall create the template for the reimbursement
11 notification form, which issuers shall fill in and
12 post on their public website.

13 (iii) An issuer may require a beneficiary to
14 submit a claim for food, travel, or lodging
15 reimbursement within 60 days of the last date of the
16 health care service for which travel was undertaken,
17 and the beneficiary may appeal any denial of
18 reimbursement claims.

19 (iv) An issuer may deny reimbursement for food,
20 lodging, and travel if the provider's site of care is
21 neither within this State nor within 100 miles of the
22 beneficiary's residence unless, after a good faith
23 effort, no provider can be found who is available
24 within those parameters to provide the medically
25 necessary health care service within 10 business days
26 of a request for appointment.

1 (B) Notwithstanding any other provision of this
2 Section to the contrary, subparagraph (A) of this
3 paragraph (3) does not apply to policies issued or
4 delivered in this State that provide medical assistance
5 under the Illinois Public Aid Code or the Children's
6 Health Insurance Program Act.

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

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

15 (g) Except for the requirements set forth in subsection
16 (d-5), insurers who are not able to comply with the provider
17 ratios and time and distance standards established by the
18 Department may request an exception to these requirements from
19 the Department. The Department may grant an exception in the
20 following circumstances:

21 (1) if no providers or facilities meet the specific
22 time and distance standard in a specific service area and
23 the insurer (i) discloses information on the distance and
24 travel time points that beneficiaries would have to travel
25 beyond the required criterion to reach the next closest
26 contracted provider outside of the service area and (ii)

1 provides contact information, including names, addresses,
2 and phone numbers for the next closest contracted provider
3 or facility;

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

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

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

20 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
21 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

22 Section 15. The Health Maintenance Organization Act is
23 amended by changing Section 5-3 as follows:

24 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

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

2 Sec. 5-3. Insurance Code provisions.

3 (a) Health Maintenance Organizations shall be subject to
4 the provisions of Sections 133, 134, 136, 137, 139, 140,
5 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
6 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
7 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,
8 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
9 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
10 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
11 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
12 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
13 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
14 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
15 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
16 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
17 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
18 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5,
19 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
20 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
21 paragraph (c) of subsection (2) of Section 367, and Articles
22 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
23 XXXIIB of the Illinois Insurance Code.

24 (b) For purposes of the Illinois Insurance Code, except
25 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
26 Health Maintenance Organizations in the following categories

1 are deemed to be "domestic companies":

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

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

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

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

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

20 (2) (i) the criteria specified in subsection (1) (b) of
21 Section 131.8 of the Illinois Insurance Code shall not
22 apply and (ii) the Director, in making his determination
23 with respect to the merger, consolidation, or other
24 acquisition of control, need not take into account the
25 effect on competition of the merger, consolidation, or
26 other acquisition of control;

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

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

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

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

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

19 (d) The provisions of Article VIII 1/2 of the Illinois
20 Insurance Code and this Section 5-3 shall apply to the sale by
21 any health maintenance organization of greater than 10% of its
22 enrollee population (including, without limitation, the health
23 maintenance organization's right, title, and interest in and
24 to its health care certificates).

25 (e) In considering any management contract or service
26 agreement subject to Section 141.1 of the Illinois Insurance

1 Code, the Director (i) shall, in addition to the criteria
2 specified in Section 141.2 of the Illinois Insurance Code,
3 take into account the effect of the management contract or
4 service agreement on the continuation of benefits to enrollees
5 and the financial condition of the health maintenance
6 organization to be managed or serviced, and (ii) need not take
7 into account the effect of the management contract or service
8 agreement on competition.

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

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

22 (ii) the amount of the refund or additional premium
23 shall not exceed 20% of the Health Maintenance
24 Organization's profitable or unprofitable experience with
25 respect to the group or other enrollment unit for the
26 period (and, for purposes of a refund or additional

1 premium, the profitable or unprofitable experience shall
2 be calculated taking into account a pro rata share of the
3 Health Maintenance Organization's administrative and
4 marketing expenses, but shall not include any refund to be
5 made or additional premium to be paid pursuant to this
6 subsection (f)). The Health Maintenance Organization and
7 the group or enrollment unit may agree that the profitable
8 or unprofitable experience may be calculated taking into
9 account the refund period and the immediately preceding 2
10 plan years.

11 The Health Maintenance Organization shall include a
12 statement in the evidence of coverage issued to each enrollee
13 describing the possibility of a refund or additional premium,
14 and upon request of any group or enrollment unit, provide to
15 the group or enrollment unit a description of the method used
16 to calculate (1) the Health Maintenance Organization's
17 profitable experience with respect to the group or enrollment
18 unit and the resulting refund to the group or enrollment unit
19 or (2) the Health Maintenance Organization's unprofitable
20 experience with respect to the group or enrollment unit and
21 the resulting additional premium to be paid by the group or
22 enrollment unit.

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

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

7 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
8 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
9 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
10 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
11 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
12 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
13 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
14 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
15 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
16 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
17 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
18 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
19 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
20 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.
21 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

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

23 Sec. 5-3. Insurance Code provisions.

24 (a) Health Maintenance Organizations shall be subject to
25 the provisions of Sections 133, 134, 136, 137, 139, 140,

1 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
2 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
3 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,
4 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
5 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
6 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
7 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
8 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
9 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
10 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
11 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
12 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
13 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
14 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5,
15 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
16 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
17 paragraph (c) of subsection (2) of Section 367, and Articles
18 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
19 XXXIIB of the Illinois Insurance Code.

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

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

26 (2) a corporation organized under the laws of this

1 State; or

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

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

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

16 (2) (i) the criteria specified in subsection (1) (b) of
17 Section 131.8 of the Illinois Insurance Code shall not
18 apply and (ii) the Director, in making his determination
19 with respect to the merger, consolidation, or other
20 acquisition of control, need not take into account the
21 effect on competition of the merger, consolidation, or
22 other acquisition of control;

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

25 (A) certification by an independent actuary of the
26 adequacy of the reserves of the Health Maintenance

1 Organization sought to be acquired;

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

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

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

15 (d) The provisions of Article VIII 1/2 of the Illinois
16 Insurance Code and this Section 5-3 shall apply to the sale by
17 any health maintenance organization of greater than 10% of its
18 enrollee population (including, without limitation, the health
19 maintenance organization's right, title, and interest in and
20 to its health care certificates).

21 (e) In considering any management contract or service
22 agreement subject to Section 141.1 of the Illinois Insurance
23 Code, the Director (i) shall, in addition to the criteria
24 specified in Section 141.2 of the Illinois Insurance Code,
25 take into account the effect of the management contract or
26 service agreement on the continuation of benefits to enrollees

1 and the financial condition of the health maintenance
2 organization to be managed or serviced, and (ii) need not take
3 into account the effect of the management contract or service
4 agreement on competition.

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

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

18 (ii) the amount of the refund or additional premium
19 shall not exceed 20% of the Health Maintenance
20 Organization's profitable or unprofitable experience with
21 respect to the group or other enrollment unit for the
22 period (and, for purposes of a refund or additional
23 premium, the profitable or unprofitable experience shall
24 be calculated taking into account a pro rata share of the
25 Health Maintenance Organization's administrative and
26 marketing expenses, but shall not include any refund to be

1 made or additional premium to be paid pursuant to this
2 subsection (f)). The Health Maintenance Organization and
3 the group or enrollment unit may agree that the profitable
4 or unprofitable experience may be calculated taking into
5 account the refund period and the immediately preceding 2
6 plan years.

7 The Health Maintenance Organization shall include a
8 statement in the evidence of coverage issued to each enrollee
9 describing the possibility of a refund or additional premium,
10 and upon request of any group or enrollment unit, provide to
11 the group or enrollment unit a description of the method used
12 to calculate (1) the Health Maintenance Organization's
13 profitable experience with respect to the group or enrollment
14 unit and the resulting refund to the group or enrollment unit
15 or (2) the Health Maintenance Organization's unprofitable
16 experience with respect to the group or enrollment unit and
17 the resulting additional premium to be paid by the group or
18 enrollment unit.

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

23 (g) Rulemaking authority to implement Public Act 95-1045,
24 if any, is conditioned on the rules being adopted in
25 accordance with all provisions of the Illinois Administrative
26 Procedure Act and all rules and procedures of the Joint

1 Committee on Administrative Rules; any purported rule not so
2 adopted, for whatever reason, is unauthorized.

3 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
4 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
5 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
6 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
7 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
8 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
9 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
10 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
11 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
12 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
13 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
14 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
15 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
16 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.
17 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
18 11-26-24.)

19 Section 20. The Voluntary Health Services Plans Act is
20 amended by changing Section 10 as follows:

21 (215 ILCS 165/10) (from Ch. 32, par. 604)

22 Sec. 10. Application of Insurance Code provisions. Health
23 services plan corporations and all persons interested therein
24 or dealing therewith shall be subject to the provisions of

1 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
2 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3,
3 355.7, 355b, 355d, 356g, 356g.5, 356g.5-1, 356m, 356q, 356r,
4 356t, 356u, 356u.10, 356v, 356w, 356x, 356y, 356z.1, 356z.2,
5 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
6 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18,
7 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
8 356z.32, 356z.32a, 356z.33, 356z.40, 356z.41, 356z.46,
9 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59,
10 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.71,
11 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408,
12 408.2, and 412, and paragraphs (7) and (15) of Section 367 of
13 the Illinois Insurance Code.

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

20 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
21 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff.
22 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,
23 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;
24 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff.
25 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
26 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;

1 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-656, eff.
2 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753,
3 eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25;
4 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff.
5 1-1-25; revised 11-26-24.)

6 Section 25. The Illinois Public Aid Code is amended by
7 changing Section 5-5.28 as follows:

8 (305 ILCS 5/5-5.28 new)

9 Sec. 5-5.28. Rulemaking authority. The Department of
10 Healthcare and Family Services may adopt rules to implement
11 the applicable provisions of this amendatory Act of the 104th
12 General Assembly to managed care organizations, managed care
13 community networks, and, at the Department's discretion, any
14 other managed care entity described in subsection (i) of
15 Section 5-30 of the Illinois Public Aid Code and the medical
16 assistance fee-for-service program.

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

1 Section 99. Effective date. This Act takes effect January
2 1, 2026.".