

1 AN ACT concerning regulation.

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

4 Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Sections 6.7 and 6.11 as follows:

6 (5 ILCS 375/6.7)

7 Sec. 6.7. Access to obstetrical and gynecological care
8 ~~Woman's health care provider.~~ The program of health benefits
9 is subject to the provisions of Section 356r of the Illinois
10 Insurance Code.

11 (Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

12 (5 ILCS 375/6.11)

13 Sec. 6.11. Required health benefits; Illinois Insurance
14 Code requirements. The program of health benefits shall
15 provide the post-mastectomy care benefits required to be
16 covered by a policy of accident and health insurance under
17 Section 356t of the Illinois Insurance Code. The program of
18 health benefits shall provide the coverage required under
19 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x,
20 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10,
21 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22,
22 356z.25, 356z.26, 356z.29, 356z.30, ~~356z.30a,~~ 356z.32,

1 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
2 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59,
3 356z.60, ~~and~~ 356z.61, ~~and~~ 356z.62, 356z.64, 356z.67, 356z.68,
4 and 356z.70 of the Illinois Insurance Code. The program of
5 health benefits must comply with Sections 155.22a, 155.37,
6 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the
7 Illinois Insurance Code. The program of health benefits shall
8 provide the coverage required under Section 356m of the
9 Illinois Insurance Code and, for the employees of the State
10 Employee Group Insurance Program only, the coverage as also
11 provided in Section 6.11B of this Act. The Department of
12 Insurance shall enforce the requirements of this Section with
13 respect to Sections 370c and 370c.1 of the Illinois Insurance
14 Code; all other requirements of this Section shall be enforced
15 by the Department of Central Management Services.

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

22 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
23 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.
24 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-768,
25 eff. 1-1-24; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;
26 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.

1 1-1-23; 102-1117, eff. 1-13-23; 103-8, eff. 1-1-24; 103-84,
2 eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24;
3 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff.
4 8-11-23; revised 8-29-23.)

5 Section 10. The Counties Code is amended by changing
6 Sections 5-1069.3 and 5-1069.5 as follows:

7 (55 ILCS 5/5-1069.3)

8 Sec. 5-1069.3. Required health benefits. If a county,
9 including a home rule county, is a self-insurer for purposes
10 of providing health insurance coverage for its employees, the
11 coverage shall include coverage for the post-mastectomy care
12 benefits required to be covered by a policy of accident and
13 health insurance under Section 356t and the coverage required
14 under Sections 356g, 356g.5, 356g.5-1, 356q, 356u, 356w, 356x,
15 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11,
16 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26,
17 356z.29, 356z.30, ~~356z.30a~~, 356z.32, 356z.33, 356z.36,
18 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51,
19 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, ~~and~~
20 356z.61, ~~and~~ 356z.62, 356z.64, 356z.67, 356z.68, and 356z.70
21 of the Illinois Insurance Code. The coverage shall comply with
22 Sections 155.22a, 355b, 356z.19, and 370c of the Illinois
23 Insurance Code. The Department of Insurance shall enforce the
24 requirements of this Section. The requirement that health

1 benefits be covered as provided in this Section is an
2 exclusive power and function of the State and is a denial and
3 limitation under Article VII, Section 6, subsection (h) of the
4 Illinois Constitution. A home rule county to which this
5 Section applies must comply with every provision of this
6 Section.

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

13 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
14 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
15 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,
16 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;
17 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.
18 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
19 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
20 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; revised
21 8-29-23.)

22 (55 ILCS 5/5-1069.5)

23 Sec. 5-1069.5. Access to obstetrical and gynecological
24 care ~~Woman's health care provider~~. All counties, including
25 home rule counties, are subject to the provisions of Section

1 356r of the Illinois Insurance Code. The requirement under
2 this Section that health care benefits provided by counties
3 comply with Section 356r of the Illinois Insurance Code is an
4 exclusive power and function of the State and is a denial and
5 limitation of home rule county powers under Article VII,
6 Section 6, subsection (h) of the Illinois Constitution.

7 (Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

8 Section 15. The Illinois Municipal Code is amended by
9 changing Sections 10-4-2.3 and 10-4-2.5 as follows:

10 (65 ILCS 5/10-4-2.3)

11 Sec. 10-4-2.3. Required health benefits. If a
12 municipality, including a home rule municipality, is a
13 self-insurer for purposes of providing health insurance
14 coverage for its employees, the coverage shall include
15 coverage for the post-mastectomy care benefits required to be
16 covered by a policy of accident and health insurance under
17 Section 356t and the coverage required under Sections 356g,
18 356g.5, 356g.5-1, 356q, 356u, 356w, 356x, 356z.4, 356z.4a,
19 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
20 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
21 ~~356z.30a,~~ 356z.32, 356z.33, 356z.36, 356z.40, 356z.41,
22 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54,
23 356z.56, 356z.57, 356z.59, 356z.60, ~~and~~ 356z.61, ~~and~~ 356z.62,
24 356z.64, 356z.67, 356z.68, and 356z.70 of the Illinois

1 Insurance Code. The coverage shall comply with Sections
2 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance
3 Code. The Department of Insurance shall enforce the
4 requirements of this Section. The requirement that health
5 benefits be covered as provided in this is an exclusive power
6 and function of the State and is a denial and limitation under
7 Article VII, Section 6, subsection (h) of the Illinois
8 Constitution. A home rule municipality to which this Section
9 applies must comply with every provision of this Section.

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

16 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
17 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
18 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,
19 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;
20 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.
21 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
22 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
23 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; revised
24 8-29-23.)

25 (65 ILCS 5/10-4-2.5)

1 Sec. 10-4-2.5. Access to obstetrical and gynecological
2 care ~~Woman's health care provider~~. The corporate authorities
3 of all municipalities are subject to the provisions of Section
4 356r of the Illinois Insurance Code. The requirement under
5 this Section that health care benefits provided by
6 municipalities comply with Section 356r of the Illinois
7 Insurance Code is an exclusive power and function of the State
8 and is a denial and limitation of home rule municipality
9 powers under Article VII, Section 6, subsection (h) of the
10 Illinois Constitution.

11 (Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

12 Section 20. The School Code is amended by changing
13 Sections 10-22.3d and 10-22.3f as follows:

14 (105 ILCS 5/10-22.3d)

15 Sec. 10-22.3d. Access to obstetrical and gynecological
16 care ~~Woman's health care provider~~. Insurance protection and
17 benefits for employees are subject to the provisions of
18 Section 356r of the Illinois Insurance Code.

19 (Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

20 (105 ILCS 5/10-22.3f)

21 Sec. 10-22.3f. Required health benefits. Insurance
22 protection and benefits for employees shall provide the
23 post-mastectomy care benefits required to be covered by a

1 policy of accident and health insurance under Section 356t and
2 the coverage required under Sections 356g, 356g.5, 356g.5-1,
3 356q, 356u, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8,
4 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,
5 356z.25, 356z.26, 356z.29, 356z.30, ~~356z.30a~~, 356z.32,
6 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
7 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,
8 ~~and~~ 356z.61, ~~and~~ 356z.62, 356z.64, 356z.67, 356z.68, and
9 356z.70 of the Illinois Insurance Code. Insurance policies
10 shall comply with Section 356z.19 of the Illinois Insurance
11 Code. The coverage shall comply with Sections 155.22a, 355b,
12 and 370c of the Illinois Insurance Code. The Department of
13 Insurance shall enforce the requirements of this Section.

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; 102-103, eff. 1-1-22;
21 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.
22 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 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; 102-1093, eff. 1-1-23; 102-1117, eff.
25 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420,
26 eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23;

1 103-551, eff. 8-11-23; revised 8-29-23.)

2 Section 25. The Illinois Insurance Code is amended by
3 changing Sections 4, 352, 352b, 356a, 356b, 356d, 356e, 356f,
4 356K, 356L, 356r, 356s, 356z.3, 356z.33, 367a, 370e, 370i,
5 408, 412, and 531.03 as follows:

6 (215 ILCS 5/4) (from Ch. 73, par. 616)

7 Sec. 4. Classes of insurance. Insurance and insurance
8 business shall be classified as follows:

9 Class 1. Life, Accident and Health.

10 (a) Life. Insurance on the lives of persons and every
11 insurance appertaining thereto or connected therewith and
12 granting, purchasing or disposing of annuities. Policies of
13 life or endowment insurance or annuity contracts or contracts
14 supplemental thereto which contain provisions for additional
15 benefits in case of death by accidental means and provisions
16 operating to safeguard such policies or contracts against
17 lapse, to give a special surrender value, or special benefit,
18 or an annuity, in the event, that the insured or annuitant
19 shall become a person with a total and permanent disability as
20 defined by the policy or contract, or which contain benefits
21 providing acceleration of life or endowment or annuity
22 benefits in advance of the time they would otherwise be
23 payable, as an indemnity for long term care which is certified
24 or ordered by a physician, including but not limited to,

1 professional nursing care, medical care expenses, custodial
2 nursing care, non-nursing custodial care provided in a nursing
3 home or at a residence of the insured, or which contain
4 benefits providing acceleration of life or endowment or
5 annuity benefits in advance of the time they would otherwise
6 be payable, at any time during the insured's lifetime, as an
7 indemnity for a terminal illness shall be deemed to be
8 policies of life or endowment insurance or annuity contracts
9 within the intent of this clause.

10 Also to be deemed as policies of life or endowment
11 insurance or annuity contracts within the intent of this
12 clause shall be those policies or riders that provide for the
13 payment of up to 75% of the face amount of benefits in advance
14 of the time they would otherwise be payable upon a diagnosis by
15 a physician licensed to practice medicine in all of its
16 branches that the insured has incurred a covered condition
17 listed in the policy or rider.

18 "Covered condition", as used in this clause, means: heart
19 attack, stroke, coronary artery surgery, life-threatening ~~life~~
20 ~~threatening~~ cancer, renal failure, Alzheimer's disease,
21 paraplegia, major organ transplantation, total and permanent
22 disability, and any other medical condition that the
23 Department may approve for any particular filing.

24 The Director may issue rules that specify prohibited
25 policy provisions, not otherwise specifically prohibited by
26 law, which in the opinion of the Director are unjust, unfair,

1 or unfairly discriminatory to the policyholder, any person
2 insured under the policy, or beneficiary.

3 (b) Accident and health. Insurance against bodily injury,
4 disablement or death by accident and against disablement
5 resulting from sickness or old age and every insurance
6 appertaining thereto, including stop-loss insurance. In this
7 clause, "stop-loss ~~stop-loss~~ insurance" means ~~is~~ insurance
8 against the risk of economic loss issued to or for the benefit
9 of a single employer self-funded employee disability benefit
10 plan or an employee welfare benefit plan as described in 29
11 U.S.C. 1001 ~~100~~ et seq., where (i) the policy is issued to and
12 insures an employer, trustee, or other sponsor of the plan, or
13 the plan itself, but not employees, members, or participants;
14 and (ii) payments by the insurer are made to the employer,
15 trustee, or other sponsors of the plan, or the plan itself, but
16 not to the employees, members, participants, or health care
17 providers. The insurance laws of this State, including this
18 Code, do not apply to arrangements between a religious
19 organization and the organization's members or participants
20 when the arrangement and organization meet all of the
21 following criteria:

22 (i) the organization is described in Section 501(c)(3)
23 of the Internal Revenue Code and is exempt from taxation
24 under Section 501(a) of the Internal Revenue Code;

25 (ii) members of the organization share a common set of
26 ethical or religious beliefs and share medical expenses

1 among members in accordance with those beliefs and without
2 regard to the state in which a member resides or is
3 employed;

4 (iii) no funds that have been given for the purpose of
5 the sharing of medical expenses among members described in
6 paragraph (ii) of this subsection (b) are held by the
7 organization in an off-shore trust or bank account;

8 (iv) the organization provides at least monthly to all
9 of its members a written statement listing the dollar
10 amount of qualified medical expenses that members have
11 submitted for sharing, as well as the amount of expenses
12 actually shared among the members;

13 (v) members of the organization retain membership even
14 after they develop a medical condition;

15 (vi) the organization or a predecessor organization
16 has been in existence at all times since December 31,
17 1999, and medical expenses of its members have been shared
18 continuously and without interruption since at least
19 December 31, 1999;

20 (vii) the organization conducts an annual audit that
21 is performed by an independent certified public accounting
22 firm in accordance with generally accepted accounting
23 principles and is made available to the public upon
24 request;

25 (viii) the organization includes the following
26 statement, in writing, on or accompanying all applications

1 and guideline materials:

2 "Notice: The organization facilitating the sharing of
3 medical expenses is not an insurance company, and
4 neither its guidelines nor plan of operation
5 constitute or create an insurance policy. Any
6 assistance you receive with your medical bills will be
7 totally voluntary. As such, participation in the
8 organization or a subscription to any of its documents
9 should never be considered to be insurance. Whether or
10 not you receive any payments for medical expenses and
11 whether or not this organization continues to operate,
12 you are always personally responsible for the payment
13 of your own medical bills.";

14 (ix) any membership card or similar document issued by
15 the organization and any written communication sent by the
16 organization to a hospital, physician, or other health
17 care provider shall include a statement that the
18 organization does not issue health insurance and that the
19 member or participant is personally liable for payment of
20 his or her medical bills;

21 (x) the organization provides to a participant, within
22 30 days after the participant joins, a complete set of its
23 rules for the sharing of medical expenses, appeals of
24 decisions made by the organization, and the filing of
25 complaints;

26 (xi) the organization does not offer any other

1 services that are regulated under any provision of the
2 Illinois Insurance Code or other insurance laws of this
3 State; and

4 (xii) the organization does not amass funds as
5 reserves intended for payment of medical services, rather
6 the organization facilitates the payments provided for in
7 this subsection (b) through payments made directly from
8 one participant to another.

9 (c) Legal Expense Insurance. Insurance which involves the
10 assumption of a contractual obligation to reimburse the
11 beneficiary against or pay on behalf of the beneficiary, all
12 or a portion of his fees, costs, or expenses related to or
13 arising out of services performed by or under the supervision
14 of an attorney licensed to practice in the jurisdiction
15 wherein the services are performed, regardless of whether the
16 payment is made by the beneficiaries individually or by a
17 third person for them, but does not include the provision of or
18 reimbursement for legal services incidental to other insurance
19 coverages. The insurance laws of this State, including this
20 Act do not apply to:

21 (i) retainer contracts made by attorneys at law with
22 individual clients with fees based on estimates of the
23 nature and amount of services to be provided to the
24 specific client, and similar contracts made with a group
25 of clients involved in the same or closely related legal
26 matters;

1 (ii) plans owned or operated by attorneys who are the
2 providers of legal services to the plan;

3 (iii) plans providing legal service benefits to groups
4 where such plans are owned or operated by authority of a
5 state, county, local or other bar association;

6 (iv) any lawyer referral service authorized or
7 operated by a state, county, local or other bar
8 association;

9 (v) the furnishing of legal assistance by labor unions
10 and other employee organizations to their members in
11 matters relating to employment or occupation;

12 (vi) the furnishing of legal assistance to members or
13 dependents, by churches, consumer organizations,
14 cooperatives, educational institutions, credit unions, or
15 organizations of employees, where such organizations
16 contract directly with lawyers or law firms for the
17 provision of legal services, and the administration and
18 marketing of such legal services is wholly conducted by
19 the organization or its subsidiary;

20 (vii) legal services provided by an employee welfare
21 benefit plan defined by the Employee Retirement Income
22 Security Act of 1974;

23 (viii) any collectively bargained plan for legal
24 services between a labor union and an employer negotiated
25 pursuant to Section 302 of the Labor Management Relations
26 Act as now or hereafter amended, under which plan legal

1 services will be provided for employees of the employer
2 whether or not payments for such services are funded to or
3 through an insurance company.

4 Class 2. Casualty, Fidelity and Surety.

5 (a) Accident and health. Insurance against bodily injury,
6 disablement or death by accident and against disablement
7 resulting from sickness or old age and every insurance
8 appertaining thereto, including stop-loss insurance. In this
9 clause, "stop-loss ~~stop-loss~~ insurance" has meaning given to
10 that term in clause (b) of Class 1 is insurance against the
11 risk of economic loss issued to a single employer self-funded
12 employee disability benefit plan or an employee welfare
13 benefit plan as described in 29 U.S.C. 1001 et seq.

14 (b) Vehicle. Insurance against any loss or liability
15 resulting from or incident to the ownership, maintenance or
16 use of any vehicle (motor or otherwise), draft animal or
17 aircraft. Any policy insuring against any loss or liability on
18 account of the bodily injury or death of any person may contain
19 a provision for payment of disability benefits to injured
20 persons and death benefits to dependents, beneficiaries or
21 personal representatives of persons who are killed, including
22 the named insured, irrespective of legal liability of the
23 insured, if the injury or death for which benefits are
24 provided is caused by accident and sustained while in or upon
25 or while entering into or alighting from or through being
26 struck by a vehicle (motor or otherwise), draft animal or

1 aircraft, and such provision shall not be deemed to be
2 accident insurance.

3 (c) Liability. Insurance against the liability of the
4 insured for the death, injury or disability of an employee or
5 other person, and insurance against the liability of the
6 insured for damage to or destruction of another person's
7 property.

8 (d) Workers' compensation. Insurance of the obligations
9 accepted by or imposed upon employers under laws for workers'
10 compensation.

11 (e) Burglary and forgery. Insurance against loss or damage
12 by burglary, theft, larceny, robbery, forgery, fraud or
13 otherwise; including all householders' personal property
14 floater risks.

15 (f) Glass. Insurance against loss or damage to glass
16 including lettering, ornamentation and fittings from any
17 cause.

18 (g) Fidelity and surety. Become surety or guarantor for
19 any person, copartnership or corporation in any position or
20 place of trust or as custodian of money or property, public or
21 private; or, becoming a surety or guarantor for the
22 performance of any person, copartnership or corporation of any
23 lawful obligation, undertaking, agreement or contract of any
24 kind, except contracts or policies of insurance; and
25 underwriting blanket bonds. Such obligations shall be known
26 and treated as suretyship obligations and such business shall

1 be known as surety business.

2 (h) Miscellaneous. Insurance against loss or damage to
3 property and any liability of the insured caused by accidents
4 to boilers, pipes, pressure containers, machinery and
5 apparatus of any kind and any apparatus connected thereto, or
6 used for creating, transmitting or applying power, light,
7 heat, steam or refrigeration, making inspection of and issuing
8 certificates of inspection upon elevators, boilers, machinery
9 and apparatus of any kind and all mechanical apparatus and
10 appliances appertaining thereto; insurance against loss or
11 damage by water entering through leaks or openings in
12 buildings, or from the breakage or leakage of a sprinkler,
13 pumps, water pipes, plumbing and all tanks, apparatus,
14 conduits and containers designed to bring water into buildings
15 or for its storage or utilization therein, or caused by the
16 falling of a tank, tank platform or supports, or against loss
17 or damage from any cause (other than causes specifically
18 enumerated under Class 3 of this Section) to such sprinkler,
19 pumps, water pipes, plumbing, tanks, apparatus, conduits or
20 containers; insurance against loss or damage which may result
21 from the failure of debtors to pay their obligations to the
22 insured; and insurance of the payment of money for personal
23 services under contracts of hiring.

24 (i) Other casualty risks. Insurance against any other
25 casualty risk not otherwise specified under Classes 1 or 3,
26 which may lawfully be the subject of insurance and may

1 properly be classified under Class 2.

2 (j) Contingent losses. Contingent, consequential and
3 indirect coverages wherein the proximate cause of the loss is
4 attributable to any one of the causes enumerated under Class
5 2. Such coverages shall, for the purpose of classification, be
6 included in the specific grouping of the kinds of insurance
7 wherein such cause is specified.

8 (k) Livestock and domestic animals. Insurance against
9 mortality, accident and health of livestock and domestic
10 animals.

11 (l) Legal expense insurance. Insurance against risk
12 resulting from the cost of legal services as defined under
13 Class 1(c).

14 Class 3. Fire and Marine, etc.

15 (a) Fire. Insurance against loss or damage by fire, smoke
16 and smudge, lightning or other electrical disturbances.

17 (b) Elements. Insurance against loss or damage by
18 earthquake, windstorms, cyclone, tornado, tempests, hail,
19 frost, snow, ice, sleet, flood, rain, drought or other weather
20 or climatic conditions including excess or deficiency of
21 moisture, rising of the waters of the ocean or its
22 tributaries.

23 (c) War, riot and explosion. Insurance against loss or
24 damage by bombardment, invasion, insurrection, riot, strikes,
25 civil war or commotion, military or usurped power, or
26 explosion (other than explosion of steam boilers and the

1 breaking of fly wheels on premises owned, controlled, managed,
2 or maintained by the insured).

3 (d) Marine and transportation. Insurance against loss or
4 damage to vessels, craft, aircraft, vehicles of every kind,
5 (excluding vehicles operating under their own power or while
6 in storage not incidental to transportation) as well as all
7 goods, freights, cargoes, merchandise, effects, disbursements,
8 profits, moneys, bullion, precious stones, securities, choses
9 in action, evidences of debt, valuable papers, bottomry and
10 respondentia interests and all other kinds of property and
11 interests therein, in respect to, appertaining to or in
12 connection with any or all risks or perils of navigation,
13 transit, or transportation, including war risks, on or under
14 any seas or other waters, on land or in the air, or while being
15 assembled, packed, crated, baled, compressed or similarly
16 prepared for shipment or while awaiting the same or during any
17 delays, storage, transshipment, or reshipment incident
18 thereto, including marine builder's risks and all personal
19 property floater risks; and for loss or damage to persons or
20 property in connection with or appertaining to marine, inland
21 marine, transit or transportation insurance, including
22 liability for loss of or damage to either arising out of or in
23 connection with the construction, repair, operation,
24 maintenance, or use of the subject matter of such insurance,
25 (but not including life insurance or surety bonds); but,
26 except as herein specified, shall not mean insurances against

1 loss by reason of bodily injury to the person; and insurance
2 against loss or damage to precious stones, jewels, jewelry,
3 gold, silver and other precious metals whether used in
4 business or trade or otherwise and whether the same be in
5 course of transportation or otherwise, which shall include
6 jewelers' block insurance; and insurance against loss or
7 damage to bridges, tunnels and other instrumentalities of
8 transportation and communication (excluding buildings, their
9 furniture and furnishings, fixed contents and supplies held in
10 storage) unless fire, tornado, sprinkler leakage, hail,
11 explosion, earthquake, riot and civil commotion are the only
12 hazards to be covered; and to piers, wharves, docks and slips,
13 excluding the risks of fire, tornado, sprinkler leakage, hail,
14 explosion, earthquake, riot and civil commotion; and to other
15 aids to navigation and transportation, including dry docks and
16 marine railways, against all risk.

17 (e) Vehicle. Insurance against loss or liability resulting
18 from or incident to the ownership, maintenance or use of any
19 vehicle (motor or otherwise), draft animal or aircraft,
20 excluding the liability of the insured for the death, injury
21 or disability of another person.

22 (f) Property damage, sprinkler leakage and crop. Insurance
23 against the liability of the insured for loss or damage to
24 another person's property or property interests from any cause
25 enumerated in this class; insurance against loss or damage by
26 water entering through leaks or openings in buildings, or from

1 the breakage or leakage of a sprinkler, pumps, water pipes,
2 plumbing and all tanks, apparatus, conduits and containers
3 designed to bring water into buildings or for its storage or
4 utilization therein, or caused by the falling of a tank, tank
5 platform or supports or against loss or damage from any cause
6 to such sprinklers, pumps, water pipes, plumbing, tanks,
7 apparatus, conduits or containers; insurance against loss or
8 damage from insects, diseases or other causes to trees, crops
9 or other products of the soil.

10 (g) Other fire and marine risks. Insurance against any
11 other property risk not otherwise specified under Classes 1 or
12 2, which may lawfully be the subject of insurance and may
13 properly be classified under Class 3.

14 (h) Contingent losses. Contingent, consequential and
15 indirect coverages wherein the proximate cause of the loss is
16 attributable to any of the causes enumerated under Class 3.
17 Such coverages shall, for the purpose of classification, be
18 included in the specific grouping of the kinds of insurance
19 wherein such cause is specified.

20 (i) Legal expense insurance. Insurance against risk
21 resulting from the cost of legal services as defined under
22 Class 1(c).

23 (Source: P.A. 101-81, eff. 7-12-19.)

24 (215 ILCS 5/352) (from Ch. 73, par. 964)

25 Sec. 352. Scope of Article.

1 (a) Except as provided in subsections (b), (c), (d), ~~and~~
2 (e), and (g), this Article shall apply to all companies
3 transacting in this State the kinds of business enumerated in
4 clause (b) of Class 1 and clause (a) of Class 2 of Section 4
5 and to all policies, contracts, and certificates of insurance
6 issued in connection therewith that are not otherwise excluded
7 under Article VII of this Code. Nothing in this Article shall
8 apply to, or in any way affect policies or contracts described
9 in clause (a) of Class 1 of Section 4; however, this Article
10 shall apply to policies and contracts which contain benefits
11 providing reimbursement for the expenses of long term health
12 care which are certified or ordered by a physician including
13 but not limited to professional nursing care, custodial
14 nursing care, and non-nursing custodial care provided in a
15 nursing home or at a residence of the insured.

16 (b) (Blank).

17 (c) A policy issued and delivered in this State that
18 provides coverage under that policy for certificate holders
19 who are neither residents of nor employed in this State does
20 not need to provide to those nonresident certificate holders
21 who are not employed in this State the coverages or services
22 mandated by this Article.

23 (d) Stop-loss insurance, as defined in clause (b) of Class
24 1 or clause (a) of Class 2 of Section 4, is exempt from all
25 Sections of this Article, except this Section and Sections
26 353a, 354, 357.30, and 370. ~~For purposes of this exemption,~~

1 ~~stop-loss insurance is further defined as follows:~~

2 ~~(1) The policy must be issued to and insure an~~
3 ~~employer, trustee, or other sponsor of the plan, or the~~
4 ~~plan itself, but not employees, members, or participants.~~

5 ~~(2) Payments by the insurer must be made to the~~
6 ~~employer, trustee, or other sponsors of the plan, or the~~
7 ~~plan itself, but not to the employees, members,~~
8 ~~participants, or health care providers.~~

9 (e) A policy issued or delivered in this State to the
10 Department of Healthcare and Family Services (formerly
11 Illinois Department of Public Aid) and providing coverage,
12 under clause (b) of Class 1 or clause (a) of Class 2 as
13 described in Section 4, to persons who are enrolled under
14 Article V of the Illinois Public Aid Code or under the
15 Children's Health Insurance Program Act is exempt from all
16 restrictions, limitations, standards, rules, or regulations
17 respecting benefits imposed by or under authority of this
18 Code, except those specified by subsection (1) of Section 143,
19 Section 370c, and Section 370c.1. Nothing in this subsection,
20 however, affects the total medical services available to
21 persons eligible for medical assistance under the Illinois
22 Public Aid Code.

23 (f) An in-office membership care agreement provided under
24 the In-Office Membership Care Act is not insurance for the
25 purposes of this Code.

26 (g) The provisions of Sections 356a through 359a, both

1 inclusive, shall not apply to or affect:

2 (1) any policy or contract of reinsurance; or

3 (2) life insurance, endowment or annuity contracts, or
4 contracts supplemental thereto that contain only such
5 provisions relating to accident and sickness insurance
6 that (A) provide additional benefits in case of death or
7 dismemberment or loss of sight by accident, or (B) operate
8 to safeguard such contracts against lapse, or to give a
9 special surrender value or special benefit or an annuity
10 if the insured or annuitant becomes a person with a total
11 and permanent disability, as defined by the contract or
12 supplemental contract.

13 (Source: P.A. 101-190, eff. 8-2-19.)

14 (215 ILCS 5/352b)

15 Sec. 352b. Excepted benefits exempted ~~Policy of individual~~
16 ~~or group accident and health insurance.~~

17 (a) Unless specified otherwise and when used in context of
18 accident and health insurance policy benefits, coverage,
19 terms, or conditions required to be provided under this
20 Article, references to any "policy of individual or group
21 accident and health insurance", or both, as used in this
22 Article, do ~~does~~ not include any coverage or policy that
23 provides an excepted benefit, as that term is defined in
24 Section 2791(c) of the federal Public Health Service Act (42
25 U.S.C. 300gg-91). Nothing in this subsection ~~amendatory Act of~~

1 ~~the 101st General Assembly~~ applies to a policy of ~~liability,~~
2 ~~workers' compensation, automobile medical payment, or~~ limited
3 scope dental or vision benefits insurance issued under this
4 Code. Nothing in this subsection shall be construed to subject
5 excepted benefits outside the scope of Section 352 to any
6 requirements of this Article.

7 (b) Nothing in this Article shall require a policy of
8 excepted benefits to provide benefits, coverage, terms, or
9 conditions in such a manner as to disqualify it from being
10 classified under federal law as the type of excepted benefit
11 for which its policy forms are filed under Sections 143 and 355
12 of this Code.

13 (Source: P.A. 101-456, eff. 8-23-19.)

14 (215 ILCS 5/356a) (from Ch. 73, par. 968a)

15 Sec. 356a. Form of policy.

16 (1) No individual policy of accident and health insurance
17 shall be delivered or issued for delivery to any person in this
18 State ~~state~~ unless:

19 (a) the entire money and other considerations therefor
20 are expressed therein; and

21 (b) the time at which the insurance takes effect and
22 terminates is expressed therein; and

23 (c) it purports to insure only one person, except that
24 a policy may insure, originally or by subsequent
25 amendment, upon the application of an adult member of a

1 family who shall be deemed the policyholder, any 2 ~~two~~ or
2 more eligible members of that family, including husband,
3 wife, dependent children or any children under a specified
4 age which shall not exceed 19 years and any other person
5 dependent upon the policyholder; and

6 (d) the style, arrangement and over-all appearance of
7 the policy give no undue prominence to any portion of the
8 text, and unless every printed portion of the text of the
9 policy and of any endorsements or attached papers is
10 plainly printed in light-faced type of a style in general
11 use, the size of which shall be uniform and not less than
12 ten-point with a lower-case unspaced alphabet length not
13 less than one hundred and twenty-point (the "text" shall
14 include all printed matter except the name and address of
15 the insurer, name or title of the policy, the brief
16 description if any, and captions and subcaptions); and

17 (e) the exceptions and reductions of indemnity are set
18 forth in the policy and, except those which are set forth
19 in Sections 357.1 through 357.30 of this act, are printed,
20 at the insurer's option, either included with the benefit
21 provision to which they apply, or under an appropriate
22 caption such as "EXCEPTIONS", or "EXCEPTIONS AND
23 REDUCTIONS", provided that if an exception or reduction
24 specifically applies only to a particular benefit of the
25 policy, a statement of such exception or reduction shall
26 be included with the benefit provision to which it

1 applies; and

2 (f) each such form, including riders and endorsements,
3 shall be identified by a form number in the lower
4 left-hand corner of the first page thereof; and

5 (g) it contains no provision purporting to make any
6 portion of the charter, rules, constitution, or by-laws of
7 the insurer a part of the policy unless such portion is set
8 forth in full in the policy, except in the case of the
9 incorporation of, or reference to, a statement of rates or
10 classification of risks, or short-rate table filed with
11 the Director.

12 (2) If any policy is issued by an insurer domiciled in this
13 state for delivery to a person residing in another state, and
14 if the official having responsibility for the administration
15 of the insurance laws of such other state shall have advised
16 the Director that any such policy is not subject to approval or
17 disapproval by such official, the Director may by ruling
18 require that such policy meet the standards set forth in
19 subsection (1) of this section and in Sections 357.1 through
20 357.30.

21 (Source: P.A. 76-860.)

22 (215 ILCS 5/356b) (from Ch. 73, par. 968b)

23 Sec. 356b. (a) This Section applies to the hospital and
24 medical expense provisions of an individual accident or health
25 insurance policy.

1 (b) If a policy provides that coverage of a dependent
2 person terminates upon attainment of the limiting age for
3 dependent persons specified in the policy, the attainment of
4 such limiting age does not operate to terminate the hospital
5 and medical coverage of a person who, because of a disabling
6 condition that occurred before attainment of the limiting age,
7 is incapable of self-sustaining employment and is dependent on
8 his or her parents or other care providers for lifetime care
9 and supervision.

10 (c) For purposes of subsection (b), "dependent on other
11 care providers" is defined as requiring a Community Integrated
12 Living Arrangement, group home, supervised apartment, or other
13 residential services licensed or certified by the Department
14 of Human Services (as successor to the Department of Mental
15 Health and Developmental Disabilities), the Department of
16 Public Health, or the Department of Healthcare and Family
17 Services (formerly Department of Public Aid).

18 (d) The insurer may inquire of the policyholder 2 months
19 prior to attainment by a dependent of the limiting age set
20 forth in the policy, or at any reasonable time thereafter,
21 whether such dependent is in fact a person who has a disability
22 and is dependent and, in the absence of proof submitted within
23 60 days of such inquiry that such dependent is a person who has
24 a disability and is dependent may terminate coverage of such
25 person at or after attainment of the limiting age. In the
26 absence of such inquiry, coverage of any person who has a

1 disability and is dependent shall continue through the term of
2 such policy or any extension or renewal thereof.

3 (e) This amendatory Act of 1969 is applicable to policies
4 issued or renewed more than 60 days after the effective date of
5 this amendatory Act of 1969.

6 (Source: P.A. 99-143, eff. 7-27-15.)

7 (215 ILCS 5/356d) (from Ch. 73, par. 968d)

8 Sec. 356d. Conversion privileges for insured former
9 spouses. (1) No individual policy of accident and health
10 insurance providing coverage of hospital and/or medical
11 expense on either an expense incurred basis or other than an
12 expense incurred basis, which in addition to covering the
13 insured also provides coverage to the spouse of the insured
14 shall contain a provision for termination of coverage for a
15 spouse covered under the policy solely as a result of a break
16 in the marital relationship except by reason of an entry of a
17 valid judgment of dissolution of marriage between the parties.

18 (2) Every policy which contains a provision for
19 termination of coverage of the spouse upon dissolution of
20 marriage shall contain a provision to the effect that upon the
21 entry of a valid judgment of dissolution of marriage between
22 the insured parties the spouse whose marriage was dissolved
23 shall be entitled to have issued to him or her, without
24 evidence of insurability, upon application made to the company
25 within 60 days following the entry of such judgment, and upon

1 the payment of the appropriate premium, an individual policy
2 of accident and health insurance. Such policy shall provide
3 the coverage then being issued by the insurer which is most
4 nearly similar to, but not greater than, such terminated
5 coverages. Any and all probationary and/or waiting periods set
6 forth in such policy shall be considered as being met to the
7 extent coverage was in force under the prior policy.

8 (3) The requirements of this Section shall apply to all
9 policies delivered or issued for delivery on or after the 60th
10 day following the effective date of this Section.

11 (Source: P.A. 84-545.)

12 (215 ILCS 5/356e) (from Ch. 73, par. 968e)

13 Sec. 356e. Victims of certain offenses.

14 (1) No individual policy of accident and health insurance,
15 which provides benefits for hospital or medical expenses based
16 upon the actual expenses incurred, delivered or issued for
17 delivery to any person in this State shall contain any
18 specific exception to coverage which would preclude the
19 payment under that policy of actual expenses incurred in the
20 examination and testing of a victim of an offense defined in
21 Sections 11-1.20 through 11-1.60 or 12-13 through 12-16 of the
22 Criminal Code of 1961 or the Criminal Code of 2012, or an
23 attempt to commit such offense to establish that sexual
24 contact did occur or did not occur, and to establish the
25 presence or absence of sexually transmitted disease or

1 infection, and examination and treatment of injuries and
2 trauma sustained by a victim of such offense arising out of the
3 offense. Every policy of accident and health insurance which
4 specifically provides benefits for routine physical
5 examinations shall provide full coverage for expenses incurred
6 in the examination and testing of a victim of an offense
7 defined in Sections 11-1.20 through 11-1.60 or 12-13 through
8 12-16 of the Criminal Code of 1961 or the Criminal Code of
9 2012, or an attempt to commit such offense as set forth in this
10 Section. This Section shall not apply to a policy which covers
11 hospital and medical expenses for specified illnesses or
12 injuries only.

13 (2) For purposes of enabling the recovery of State funds,
14 any insurance carrier subject to this Section shall upon
15 reasonable demand by the Department of Public Health disclose
16 the names and identities of its insureds entitled to benefits
17 under this provision to the Department of Public Health
18 whenever the Department of Public Health has determined that
19 it has paid, or is about to pay, hospital or medical expenses
20 for which an insurance carrier is liable under this Section.
21 All information received by the Department of Public Health
22 under this provision shall be held on a confidential basis and
23 shall not be subject to subpoena and shall not be made public
24 by the Department of Public Health or used for any purpose
25 other than that authorized by this Section.

26 (3) Whenever the Department of Public Health finds that it

1 has paid all or part of any hospital or medical expenses which
2 an insurance carrier is obligated to pay under this Section,
3 the Department of Public Health shall be entitled to receive
4 reimbursement for its payments from such insurance carrier
5 provided that the Department of Public Health has notified the
6 insurance carrier of its claims before the carrier has paid
7 such benefits to its insureds or in behalf of its insureds.

8 (Source: P.A. 96-1551, eff. 7-1-11; 97-1150, eff. 1-25-13.)

9 (215 ILCS 5/356f) (from Ch. 73, par. 968f)

10 Sec. 356f. No individual policy of accident or health
11 insurance or any renewal thereof shall be denied or cancelled
12 by the insurer, nor shall any such policy contain any
13 exception or exclusion of benefits, solely because the mother
14 of the insured has taken diethylstilbestrol, commonly referred
15 to as DES.

16 (Source: P.A. 81-656.)

17 (215 ILCS 5/356K) (from Ch. 73, par. 968K)

18 Sec. 356K. Coverage for Organ Transplantation Procedures.
19 No ~~accident and health~~ insurer providing individual accident
20 and health insurance coverage under this Act for hospital or
21 medical expenses shall deny reimbursement for an otherwise
22 covered expense incurred for any organ transplantation
23 procedure solely on the basis that such procedure is deemed
24 experimental or investigational unless supported by the

1 determination of the Office of Health Care Technology
2 Assessment within the Agency for Health Care Policy and
3 Research within the federal Department of Health and Human
4 Services that such procedure is either experimental or
5 investigational or that there is insufficient data or
6 experience to determine whether an organ transplantation
7 procedure is clinically acceptable. If an accident and health
8 insurer has made written request, or had one made on its behalf
9 by a national organization, for determination by the Office of
10 Health Care Technology Assessment within the Agency for Health
11 Care Policy and Research within the federal Department of
12 Health and Human Services as to whether a specific organ
13 transplantation procedure is clinically acceptable and said
14 organization fails to respond to such a request within a
15 period of 90 days, the failure to act may be deemed a
16 determination that the procedure is deemed to be experimental
17 or investigational.

18 (Source: P.A. 87-218.)

19 (215 ILCS 5/356L) (from Ch. 73, par. 968L)

20 Sec. 356L. No individual policy of accident or health
21 insurance shall include any provision which shall have the
22 effect of denying coverage to or on behalf of an insured under
23 such policy on the basis of a failure by the insured to file a
24 notice of claim within the time period required by the policy,
25 provided such failure is caused solely by the physical

1 inability or mental incapacity of the insured to file such
2 notice of claim because of a period of emergency
3 hospitalization.

4 (Source: P.A. 86-784.)

5 (215 ILCS 5/356r)

6 Sec. 356r. Access to obstetrical and gynecological care
7 ~~Woman's principal health care provider.~~

8 (a) An individual or group policy of accident and health
9 insurance or a managed care plan amended, delivered, issued,
10 or renewed in this State must not require authorization or
11 referral by the plan, issuer, or any person, including a
12 primary care provider, for any covered individual who seeks
13 coverage for obstetrical or gynecological care provided by any
14 licensed or certified participating health care professional
15 who specializes in obstetrics or gynecology. ~~after November~~
16 ~~14, 1996 that requires an insured or enrollee to designate an~~
17 ~~individual to coordinate care or to control access to health~~
18 ~~care services shall also permit a female insured or enrollee~~
19 ~~to designate a participating woman's principal health care~~
20 ~~provider, and the insurer or managed care plan shall provide~~
21 ~~the following written notice to all female insureds or~~
22 ~~enrollees no later than 120 days after the effective date of~~
23 ~~this amendatory Act of 1998; to all new enrollees at the time~~
24 ~~of enrollment; and thereafter to all existing enrollees at~~
25 ~~least annually, as a part of a regular publication or~~

1 ~~informational mailing:~~

2 ~~"NOTICE TO ALL FEMALE PLAN MEMBERS:~~

3 ~~YOUR RIGHT TO SELECT A WOMAN'S PRINCIPAL~~

4 ~~HEALTH CARE PROVIDER.~~

5 ~~Illinois law allows you to select "a woman's principal~~
6 ~~health care provider" in addition to your selection of a~~
7 ~~primary care physician. A woman's principal health care~~
8 ~~provider is a physician licensed to practice medicine in~~
9 ~~all its branches specializing in obstetrics or gynecology~~
10 ~~or specializing in family practice. A woman's principal~~
11 ~~health care provider may be seen for care without~~
12 ~~referrals from your primary care physician. If you have~~
13 ~~not already selected a woman's principal health care~~
14 ~~provider, you may do so now or at any other time. You are~~
15 ~~not required to have or to select a woman's principal~~
16 ~~health care provider.~~

17 ~~Your woman's principal health care provider must be a~~
18 ~~part of your plan. You may get the list of participating~~
19 ~~obstetricians, gynecologists, and family practice~~
20 ~~specialists from your employer's employee benefits~~
21 ~~coordinator, or for your own copy of the current list, you~~
22 ~~may call [insert plan's toll free number]. The list will~~
23 ~~be sent to you within 10 days after your call. To designate~~
24 ~~a woman's principal health care provider from the list,~~
25 ~~call [insert plan's toll free number] and tell our staff~~
26 ~~the name of the physician you have selected."~~

1 ~~If the insurer or managed care plan exercises the option set~~
2 ~~forth in subsection (a-5), the notice shall also state:~~

3 ~~"Your plan requires that your primary care physician~~
4 ~~and your woman's principal health care provider have a~~
5 ~~referral arrangement with one another. If the woman's~~
6 ~~principal health care provider that you select does not~~
7 ~~have a referral arrangement with your primary care~~
8 ~~physician, you will have to select a new primary care~~
9 ~~physician who has a referral arrangement with your woman's~~
10 ~~principal health care provider or you may select a woman's~~
11 ~~principal health care provider who has a referral~~
12 ~~arrangement with your primary care physician. The list of~~
13 ~~woman's principal health care providers will also have the~~
14 ~~names of the primary care physicians and their referral~~
15 ~~arrangements.".~~

16 ~~No later than 120 days after the effective date of this~~
17 ~~amendatory Act of 1998, the insurer or managed care plan shall~~
18 ~~provide each employer who has a policy of insurance or a~~
19 ~~managed care plan with the insurer or managed care plan with a~~
20 ~~list of physicians licensed to practice medicine in all its~~
21 ~~branches specializing in obstetrics or gynecology or~~
22 ~~specializing in family practice who have contracted with the~~
23 ~~plan. At the time of enrollment and thereafter within 10 days~~
24 ~~after a request by an insured or enrollee, the insurer or~~
25 ~~managed care plan also shall provide this list directly to the~~
26 ~~insured or enrollee. The list shall include each physician's~~

1 ~~address, telephone number, and specialty. No insurer or plan~~
2 ~~formal or informal policy may restrict a female insured's or~~
3 ~~enrollee's right to designate a woman's principal health care~~
4 ~~provider, except as set forth in subsection (a-5). If the~~
5 ~~female enrollee is an enrollee of a managed care plan under~~
6 ~~contract with the Department of Healthcare and Family~~
7 ~~Services, the physician chosen by the enrollee as her woman's~~
8 ~~principal health care provider must be a Medicaid enrolled~~
9 ~~provider. This requirement does not require a female insured~~
10 ~~or enrollee to make a selection of a woman's principal health~~
11 ~~care provider. The female insured or enrollee may designate a~~
12 ~~physician licensed to practice medicine in all its branches~~
13 ~~specializing in family practice as her woman's principal~~
14 ~~health care provider.~~

15 (a-5) If a policy, contract, or certificate requires or
16 allows a covered individual to designate a primary care
17 provider and provides coverage for any obstetrical or
18 gynecological care, the insurer shall provide the notice
19 required under 45 CFR 147.138(a)(4) and 149.310(a)(4) in all
20 circumstances required under that provision. ~~The insured or~~
21 ~~enrollee may be required by the insurer or managed care plan to~~
22 ~~select a woman's principal health care provider who has a~~
23 ~~referral arrangement with the insured's or enrollee's~~
24 ~~individual who coordinates care or controls access to health~~
25 ~~care services if such referral arrangement exists or to select~~
26 ~~a new individual to coordinate care or to control access to~~

1 ~~health care services who has a referral arrangement with the~~
2 ~~woman's principal health care provider chosen by the insured~~
3 ~~or enrollee, if such referral arrangement exists. If an~~
4 ~~insurer or a managed care plan requires an insured or enrollee~~
5 ~~to select a new physician under this subsection (a 5), the~~
6 ~~insurer or managed care plan must provide the insured or~~
7 ~~enrollee with both options to select a new physician provided~~
8 ~~in this subsection (a 5).~~

9 ~~Notwithstanding a plan's restrictions of the frequency or~~
10 ~~timing of making designations of primary care providers, a~~
11 ~~female enrollee or insured who is subject to the selection~~
12 ~~requirements of this subsection, may, at any time, effect a~~
13 ~~change in primary care physicians in order to make a selection~~
14 ~~of a woman's principal health care provider.~~

15 ~~(a-6) The requirements of this Section shall be construed~~
16 ~~in a manner consistent with the requirements for access to and~~
17 ~~notice of obstetrical and gynecological care in 45 CFR 147.138~~
18 ~~and 45 CFR 149.310. If an insurer or managed care plan~~
19 ~~exercises the option in subsection (a 5), the list to be~~
20 ~~provided under subsection (a) shall identify the referral~~
21 ~~arrangements that exist between the individual who coordinates~~
22 ~~care or controls access to health care services and the~~
23 ~~woman's principal health care provider in order to assist the~~
24 ~~female insured or enrollee to make a selection within the~~
25 ~~insurer's or managed care plan's requirement.~~

26 ~~(b) Nothing in this Section prevents a health insurance~~

1 issuer from requiring a participating obstetrical or
2 gynecological health care professional to agree, with respect
3 to individuals covered under a policy of accident and health
4 insurance, to otherwise adhere to the health insurance
5 issuer's policies and procedures, including procedures
6 regarding referrals and obtaining prior authorization and
7 providing services pursuant to a treatment plan, if any,
8 approved by the issuer. ~~If a female insured or enrollee has~~
9 ~~designated a woman's principal health care provider, then the~~
10 ~~insured or enrollee must be given direct access to the woman's~~
11 ~~principal health care provider for services covered by the~~
12 ~~policy or plan without the need for a referral or prior~~
13 ~~approval. Nothing shall prohibit the insurer or managed care~~
14 ~~plan from requiring prior authorization or approval from~~
15 ~~either a primary care provider or the woman's principal health~~
16 ~~care provider for referrals for additional care or services.~~

17 (c) (Blank). ~~For the purposes of this Section the~~
18 ~~following terms are defined:~~

19 ~~(1) "Woman's principal health care provider" means a~~
20 ~~physician licensed to practice medicine in all of its~~
21 ~~branches specializing in obstetrics or gynecology or~~
22 ~~specializing in family practice.~~

23 ~~(2) "Managed care entity" means any entity including a~~
24 ~~licensed insurance company, hospital or medical service~~
25 ~~plan, health maintenance organization, limited health~~
26 ~~service organization, preferred provider organization,~~

1 ~~third party administrator, an employer or employee~~
2 ~~organization, or any person or entity that establishes,~~
3 ~~operates, or maintains a network of participating~~
4 ~~providers.~~

5 ~~(3) "Managed care plan" means a plan operated by a~~
6 ~~managed care entity that provides for the financing of~~
7 ~~health care services to persons enrolled in the plan~~
8 ~~through:~~

9 ~~(A) organizational arrangements for ongoing~~
10 ~~quality assurance, utilization review programs, or~~
11 ~~dispute resolution; or~~

12 ~~(B) financial incentives for persons enrolled in~~
13 ~~the plan to use the participating providers and~~
14 ~~procedures covered by the plan.~~

15 ~~(4) "Participating provider" means a physician who has~~
16 ~~contracted with an insurer or managed care plan to provide~~
17 ~~services to insureds or enrollees as defined by the~~
18 ~~contract.~~

19 (d) Nothing in this Section shall be construed to preclude
20 a health insurance issuer from requiring that a participating
21 obstetrical or gynecological health care professional notify
22 the covered individual's primary care physician or the issuer
23 of treatment decisions or update centralized medical records.
24 ~~The original provisions of this Section became law on July 17,~~
25 ~~1996 and took effect November 14, 1996, which is 120 days after~~
26 ~~becoming law.~~

1 (Source: P.A. 95-331, eff. 8-21-07.)

2 (215 ILCS 5/356s)

3 Sec. 356s. Post-parturition care. An individual or group
4 policy of accident and health insurance that provides
5 maternity coverage and is amended, delivered, issued, or
6 renewed after the effective date of this amendatory Act of
7 1996 shall provide coverage for the following:

8 (1) a minimum of 48 hours of inpatient care following
9 a vaginal delivery for the mother and the newborn, except
10 as otherwise provided in this Section; or

11 (2) a minimum of 96 hours of inpatient care following
12 a delivery by caesarian section for the mother and
13 newborn, except as otherwise provided in this Section.

14 Coverage may be limited to a ~~A~~ shorter length of ~~hospital~~
15 inpatient care stay ~~stay~~ for services related to maternity and
16 newborn care ~~may be provided~~ if the attending physician
17 licensed to practice medicine in all of its branches
18 determines, in accordance with the protocols and guidelines
19 developed by the American College of Obstetricians and
20 Gynecologists or the American Academy of Pediatrics, that the
21 mother and the newborn meet the appropriate guidelines for
22 that length of stay based upon evaluation of the mother and
23 newborn and the coverage and availability of a post-discharge
24 physician office visit or in-home nurse visit to verify the
25 condition of the infant in the first 48 hours after discharge.

1 (Source: P.A. 89-513, eff. 9-15-96; 90-14, eff. 7-1-97.)

2 (215 ILCS 5/356z.3)

3 Sec. 356z.3. Disclosure of limited benefit. An insurer
4 that issues, delivers, amends, or renews an individual or
5 group policy of accident and health insurance in this State
6 after the effective date of this amendatory Act of the 92nd
7 General Assembly and arranges, contracts with, or administers
8 contracts with a provider whereby beneficiaries are provided
9 an incentive to use the services of such provider must include
10 the following disclosure on its contracts and evidences of
11 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN
12 NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO PAY
13 MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN
14 NON-EMERGENCY SITUATIONS. Except in limited situations
15 governed by the federal No Surprises Act or Section 356z.3a of
16 the Illinois Insurance Code (215 ILCS 5/356z.3a),
17 non-participating providers furnishing non-emergency services
18 may bill members for any amount up to the billed charge after
19 the plan has paid its portion of the bill. If you elect to use
20 a non-participating provider, plan benefit payments will be
21 determined according to your policy's fee schedule, usual and
22 customary charge (which is determined by comparing charges for
23 similar services adjusted to the geographical area where the
24 services are performed), or other method as defined by the
25 policy. Participating providers have agreed to ONLY bill

1 members the cost-sharing amounts. ~~You should be aware that~~
2 ~~when you elect to utilize the services of a non-participating~~
3 ~~provider for a covered service in non-emergency situations,~~
4 ~~benefit payments to such non-participating provider are not~~
5 ~~based upon the amount billed. The basis of your benefit~~
6 ~~payment will be determined according to your policy's fee~~
7 ~~schedule, usual and customary charge (which is determined by~~
8 ~~comparing charges for similar services adjusted to the~~
9 ~~geographical area where the services are performed), or other~~
10 ~~method as defined by the policy. YOU CAN EXPECT TO PAY MORE~~
11 ~~THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE~~
12 ~~PLAN HAS PAID ITS REQUIRED PORTION. Non-participating~~
13 ~~providers may bill members for any amount up to the billed~~
14 ~~charge after the plan has paid its portion of the bill, except~~
15 ~~as provided in Section 356z.3a of the Illinois Insurance Code~~
16 ~~for covered services received at a participating health care~~
17 ~~facility from a nonparticipating provider that are: (a)~~
18 ~~ancillary services, (b) items or services furnished as a~~
19 ~~result of unforeseen, urgent medical needs that arise at the~~
20 ~~time the item or service is furnished, or (c) items or services~~
21 ~~received when the facility or the non-participating provider~~
22 ~~fails to satisfy the notice and consent criteria specified~~
23 ~~under Section 356z.3a. Participating providers have agreed to~~
24 ~~accept discounted payments for services with no additional~~
25 ~~billing to the member other than co-insurance and deductible~~
26 ~~amounts.~~ You may obtain further information about the

1 participating status of professional providers and information
2 on out-of-pocket expenses by calling the toll-free ~~toll-free~~
3 telephone number on your identification card.".

4 (Source: P.A. 102-901, eff. 1-1-23.)

5 (215 ILCS 5/356z.33)

6 (Text of Section before amendment by P.A. 103-454)

7 Sec. 356z.33. Coverage for epinephrine injectors. A group
8 or individual policy of accident and health insurance or a
9 managed care plan that is amended, delivered, issued, or
10 renewed on or after January 1, 2020 (the effective date of
11 Public Act 101-281) shall provide coverage for medically
12 necessary epinephrine injectors for persons 18 years of age or
13 under. As used in this Section, "epinephrine injector" has the
14 meaning given to that term in Section 5 of the Epinephrine
15 Injector Act.

16 (Source: P.A. 101-281, eff. 1-1-20; 102-558, eff. 8-20-21.)

17 (Text of Section after amendment by P.A. 103-454)

18 Sec. 356z.33. Coverage for epinephrine injectors.

19 (a) A group or individual policy of accident and health
20 insurance or a managed care plan that is amended, delivered,
21 issued, or renewed on or after January 1, 2020 (the effective
22 date of Public Act 101-281) shall provide coverage for
23 medically necessary epinephrine injectors for persons 18 years
24 of age or under. As used in this Section, "epinephrine

1 injector" has the meaning given to that term in Section 5 of
2 the Epinephrine Injector Act.

3 (b) An insurer that provides coverage for medically
4 necessary epinephrine injectors shall limit the total amount
5 that an insured is required to pay for a twin-pack of medically
6 necessary epinephrine injectors at an amount not to exceed
7 \$60, regardless of the type of epinephrine injector; except
8 that this provision does not apply to the extent such coverage
9 would disqualify a high-deductible health plan from
10 eligibility for a health savings account pursuant to Section
11 223 of the Internal Revenue Code (26 U.S.C. 223).

12 (c) Nothing in this Section prevents an insurer from
13 reducing an insured's cost sharing by an amount greater than
14 the amount specified in subsection (b).

15 (d) The Department may adopt rules as necessary to
16 implement and administer this Section.

17 (Source: P.A. 102-558, eff. 8-20-21; 103-454, eff. 1-1-25.)

18 (215 ILCS 5/367a) (from Ch. 73, par. 979a)

19 Sec. 367a. Blanket accident and health insurance.

20 (1) Blanket accident and health insurance is that form of
21 accident and health insurance covering special groups of
22 persons as enumerated in one of the following paragraphs (a)
23 to (g), inclusive:

24 (a) Under a policy or contract issued to any carrier
25 for hire, which shall be deemed the policyholder, covering

1 a group defined as all persons who may become passengers
2 on such carrier.

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

7 (c) Under a policy or contract issued to a college,
8 school, or other institution of learning or to the head or
9 principal thereof, who or which shall be deemed the
10 policyholder, covering students or teachers. However,
11 student health insurance coverage, as defined in 45 CFR
12 147.145, shall remain subject to the standards and
13 requirements for individual health insurance coverage
14 except where inconsistent with that regulation. Student
15 health insurance coverage shall not be subject to the
16 Short-Term, Limited-Duration Health Insurance Coverage
17 Act. An insurer providing student health insurance
18 coverage or a policy or contract covering students for
19 limited-scope dental or vision under 45 CFR 148.220 shall
20 require an individual application or enrollment form and
21 shall furnish each insured individual a certificate, which
22 shall have been approved by the Director under Section
23 355.

24 (d) Under a policy or contract issued in the name of
25 any volunteer fire department, first aid, or other such
26 volunteer group, which shall be deemed the policyholder,

1 covering all of the members of such department or group.

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

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

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

16 (2) Any insurance company authorized to write accident and
17 health insurance in this state shall have the power to issue
18 blanket accident and health insurance. No such blanket policy
19 may be issued or delivered in this State unless a copy of the
20 form thereof shall have been filed in accordance with Section
21 355, and it contains in substance such of those provisions
22 contained in Sections 357.1 through 357.30 as may be
23 applicable to blanket accident and health insurance and the
24 following provisions:

25 (a) A provision that the policy and the application
26 shall constitute the entire contract between the parties,

1 and that all statements made by the policyholder shall, in
2 absence of fraud, be deemed representations and not
3 warranties, and that no such statements shall be used in
4 defense to a claim under the policy, unless it is
5 contained in a written application.

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

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

13 (3.5) Subsection (3) does not apply to major medical
14 insurance, or to any excepted benefits or short-term,
15 limited-duration health insurance coverage for which an
16 insured individual pays premiums or contributions. In those
17 cases, the insurer shall require an individual application or
18 enrollment form and shall furnish each insured individual a
19 certificate, which shall have been approved by the Director
20 under Section 355 of this Code.

21 (4) All benefits under any blanket accident and health
22 policy shall be payable to the person insured, or to his
23 designated beneficiary or beneficiaries, or to his or her
24 estate, except that if the person insured be a minor or person
25 under legal disability, such benefits may be made payable to
26 his or her parent, guardian, or other person actually

1 supporting him or her. Provided further, however, that the
2 policy may provide that all or any portion of any indemnities
3 provided by any such policy on account of hospital, nursing,
4 medical or surgical services may, at the insurer's option, be
5 paid directly to the hospital or person rendering such
6 services; but the policy may not require that the service be
7 rendered by a particular hospital or person. Payment so made
8 shall discharge the insurer's obligation with respect to the
9 amount of insurance so paid.

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

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

14 (215 ILCS 5/370e) (from Ch. 73, par. 982e)

15 Sec. 370e. Companies which issue group accident and health
16 policies or blanket accident and health plans to employer
17 groups in this State shall provide the employer with notice of
18 termination of a group or blanket accident and health plan
19 because of the employer's failure to pay the premium when due.
20 The insurance company shall file ~~send~~ a copy of such notice
21 with ~~to~~ the Department in an electronic format either through
22 the System for Electronic Rate and Form Filing (SERFF) or as
23 otherwise prescribed by the Director.

24 (Source: P.A. 83-1006.)

1 (215 ILCS 5/370i) (from Ch. 73, par. 982i)

2 Sec. 370i. Policies, agreements or arrangements with
3 incentives or limits on reimbursement authorized.

4 (a) Policies, agreements or arrangements issued under this
5 Article may not contain terms or conditions that would operate
6 unreasonably to restrict the access and availability of health
7 care services for the insured.

8 (b) An insurer or administrator may:

9 (1) enter into agreements with certain providers of
10 its choice relating to health care services which may be
11 rendered to insureds or beneficiaries of the insurer or
12 administrator, including agreements relating to the
13 amounts to be charged the insureds or beneficiaries for
14 services rendered;

15 (2) issue or administer programs, policies or
16 subscriber contracts in this State that include incentives
17 for the insured or beneficiary to utilize the services of
18 a provider which has entered into an agreement with the
19 insurer or administrator pursuant to paragraph (1) above.

20 (c) ~~(Blank). After the effective date of this amendatory~~
21 ~~Act of the 92nd General Assembly, any insurer that arranges,~~
22 ~~contracts with, or administers contracts with a provider~~
23 ~~whereby beneficiaries are provided an incentive to use the~~
24 ~~services of such provider must include the following~~
25 ~~disclosure on its contracts and evidences of coverage:~~
26 ~~"WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON PARTICIPATING~~

1 ~~PROVIDERS ARE USED. You should be aware that when you elect to~~
2 ~~utilize the services of a non-participating provider for a~~
3 ~~covered service in non-emergency situations, benefit payments~~
4 ~~to such non-participating provider are not based upon the~~
5 ~~amount billed. The basis of your benefit payment will be~~
6 ~~determined according to your policy's fee schedule, usual and~~
7 ~~customary charge (which is determined by comparing charges for~~
8 ~~similar services adjusted to the geographical area where the~~
9 ~~services are performed), or other method as defined by the~~
10 ~~policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT~~
11 ~~DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED~~
12 ~~PORTION. Non-participating providers may bill members for any~~
13 ~~amount up to the billed charge after the plan has paid its~~
14 ~~portion of the bill. Participating providers have agreed to~~
15 ~~accept discounted payments for services with no additional~~
16 ~~billing to the member other than co insurance and deductible~~
17 ~~amounts. You may obtain further information about the~~
18 ~~participating status of professional providers and information~~
19 ~~on out of pocket expenses by calling the toll free telephone~~
20 ~~number on your identification card."-~~

21 (Source: P.A. 92-579, eff. 1-1-03.)

22 (215 ILCS 5/408) (from Ch. 73, par. 1020)

23 (Text of Section before amendment by P.A. 103-75)

24 Sec. 408. Fees and charges.

25 (1) The Director shall charge, collect and give proper

1 acquittances for the payment of the following fees and
2 charges:

3 (a) For filing all documents submitted for the
4 incorporation or organization or certification of a
5 domestic company, except for a fraternal benefit society,
6 \$2,000.

7 (b) For filing all documents submitted for the
8 incorporation or organization of a fraternal benefit
9 society, \$500.

10 (c) For filing amendments to articles of incorporation
11 and amendments to declaration of organization, except for
12 a fraternal benefit society, a mutual benefit association,
13 a burial society or a farm mutual, \$200.

14 (d) For filing amendments to articles of incorporation
15 of a fraternal benefit society, a mutual benefit
16 association or a burial society, \$100.

17 (e) For filing amendments to articles of incorporation
18 of a farm mutual, \$50.

19 (f) For filing bylaws or amendments thereto, \$50.

20 (g) For filing agreement of merger or consolidation:

21 (i) for a domestic company, except for a fraternal
22 benefit society, a mutual benefit association, a
23 burial society, or a farm mutual, \$2,000.

24 (ii) for a foreign or alien company, except for a
25 fraternal benefit society, \$600.

26 (iii) for a fraternal benefit society, a mutual

1 benefit association, a burial society, or a farm
2 mutual, \$200.

3 (h) For filing agreements of reinsurance by a domestic
4 company, \$200.

5 (i) For filing all documents submitted by a foreign or
6 alien company to be admitted to transact business or
7 accredited as a reinsurer in this State, except for a
8 fraternal benefit society, \$5,000.

9 (j) For filing all documents submitted by a foreign or
10 alien fraternal benefit society to be admitted to transact
11 business in this State, \$500.

12 (k) For filing declaration of withdrawal of a foreign
13 or alien company, \$50.

14 (l) For filing annual statement by a domestic company,
15 except a fraternal benefit society, a mutual benefit
16 association, a burial society, or a farm mutual, \$200.

17 (m) For filing annual statement by a domestic
18 fraternal benefit society, \$100.

19 (n) For filing annual statement by a farm mutual, a
20 mutual benefit association, or a burial society, \$50.

21 (o) For issuing a certificate of authority or renewal
22 thereof except to a foreign fraternal benefit society,
23 \$400.

24 (p) For issuing a certificate of authority or renewal
25 thereof to a foreign fraternal benefit society, \$200.

26 (q) For issuing an amended certificate of authority,

1 \$50.

2 (r) For each certified copy of certificate of
3 authority, \$20.

4 (s) For each certificate of deposit, or valuation, or
5 compliance or surety certificate, \$20.

6 (t) For copies of papers or records per page, \$1.

7 (u) For each certification to copies of papers or
8 records, \$10.

9 (v) For multiple copies of documents or certificates
10 listed in subparagraphs (r), (s), and (u) of paragraph (1)
11 of this Section, \$10 for the first copy of a certificate of
12 any type and \$5 for each additional copy of the same
13 certificate requested at the same time, unless, pursuant
14 to paragraph (2) of this Section, the Director finds these
15 additional fees excessive.

16 (w) For issuing a permit to sell shares or increase
17 paid-up capital:

18 (i) in connection with a public stock offering,
19 \$300;

20 (ii) in any other case, \$100.

21 (x) For issuing any other certificate required or
22 permissible under the law, \$50.

23 (y) For filing a plan of exchange of the stock of a
24 domestic stock insurance company, a plan of
25 demutualization of a domestic mutual company, or a plan of
26 reorganization under Article XII, \$2,000.

1 (z) For filing a statement of acquisition of a
2 domestic company as defined in Section 131.4 of this Code,
3 \$2,000.

4 (aa) For filing an agreement to purchase the business
5 of an organization authorized under the Dental Service
6 Plan Act or the Voluntary Health Services Plans Act or of a
7 health maintenance organization or a limited health
8 service organization, \$2,000.

9 (bb) For filing a statement of acquisition of a
10 foreign or alien insurance company as defined in Section
11 131.12a of this Code, \$1,000.

12 (cc) For filing a registration statement as required
13 in Sections 131.13 and 131.14, the notification as
14 required by Sections 131.16, 131.20a, or 141.4, or an
15 agreement or transaction required by Sections 124.2(2),
16 141, 141a, or 141.1, \$200.

17 (dd) For filing an application for licensing of:

18 (i) a religious or charitable risk pooling trust
19 or a workers' compensation pool, \$1,000;

20 (ii) a workers' compensation service company,
21 \$500;

22 (iii) a self-insured automobile fleet, \$200; or

23 (iv) a renewal of or amendment of any license
24 issued pursuant to (i), (ii), or (iii) above, \$100.

25 (ee) For filing articles of incorporation for a
26 syndicate to engage in the business of insurance through

1 the Illinois Insurance Exchange, \$2,000.

2 (ff) For filing amended articles of incorporation for
3 a syndicate engaged in the business of insurance through
4 the Illinois Insurance Exchange, \$100.

5 (gg) For filing articles of incorporation for a
6 limited syndicate to join with other subscribers or
7 limited syndicates to do business through the Illinois
8 Insurance Exchange, \$1,000.

9 (hh) For filing amended articles of incorporation for
10 a limited syndicate to do business through the Illinois
11 Insurance Exchange, \$100.

12 (ii) For a permit to solicit subscriptions to a
13 syndicate or limited syndicate, \$100.

14 (jj) For the filing of each form as required in
15 Section 143 of this Code, \$50 per form. Informational and
16 advertising filings shall be \$25 per filing. The fee for
17 advisory and rating organizations shall be \$200 per form.

18 (i) For the purposes of the form filing fee,
19 filings made on insert page basis will be considered
20 one form at the time of its original submission.
21 Changes made to a form subsequent to its approval
22 shall be considered a new filing.

23 (ii) Only one fee shall be charged for a form,
24 regardless of the number of other forms or policies
25 with which it will be used.

26 (iii) Fees charged for a policy filed as it will be

1 issued regardless of the number of forms comprising
2 that policy shall not exceed \$1,500. For advisory or
3 rating organizations, fees charged for a policy filed
4 as it will be issued regardless of the number of forms
5 comprising that policy shall not exceed \$2,500.

6 (iv) The Director may by rule exempt forms from
7 such fees.

8 (kk) For filing an application for licensing of a
9 reinsurance intermediary, \$500.

10 (ll) For filing an application for renewal of a
11 license of a reinsurance intermediary, \$200.

12 (mm) For filing a plan of division of a domestic stock
13 company under Article IIB, \$100,000 ~~\$10,000~~.

14 (nn) For filing all documents submitted by a foreign
15 or alien company to be a certified reinsurer in this
16 State, except for a fraternal benefit society, \$1,000.

17 (oo) For filing a renewal by a foreign or alien
18 company to be a certified reinsurer in this State, except
19 for a fraternal benefit society, \$400.

20 (pp) For filing all documents submitted by a reinsurer
21 domiciled in a reciprocal jurisdiction, \$1,000.

22 (qq) For filing a renewal by a reinsurer domiciled in
23 a reciprocal jurisdiction, \$400.

24 (rr) For registering a captive management company or
25 renewal thereof, \$50.

26 (2) When printed copies or numerous copies of the same

1 paper or records are furnished or certified, the Director may
2 reduce such fees for copies if he finds them excessive. He may,
3 when he considers it in the public interest, furnish without
4 charge to state insurance departments and persons other than
5 companies, copies or certified copies of reports of
6 examinations and of other papers and records.

7 (3) The expenses incurred in any performance examination
8 authorized by law shall be paid by the company or person being
9 examined. The charge shall be reasonably related to the cost
10 of the examination including but not limited to compensation
11 of examiners, electronic data processing costs, supervision
12 and preparation of an examination report and lodging and
13 travel expenses. All lodging and travel expenses shall be in
14 accord with the applicable travel regulations as published by
15 the Department of Central Management Services and approved by
16 the Governor's Travel Control Board, except that out-of-state
17 lodging and travel expenses related to examinations authorized
18 under Section 132 shall be in accordance with travel rates
19 prescribed under paragraph 301-7.2 of the Federal Travel
20 Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of
21 subsistence expenses incurred during official travel. All
22 lodging and travel expenses may be reimbursed directly upon
23 authorization of the Director. With the exception of the
24 direct reimbursements authorized by the Director, all
25 performance examination charges collected by the Department
26 shall be paid to the Insurance Producer Administration Fund,

1 however, the electronic data processing costs incurred by the
2 Department in the performance of any examination shall be
3 billed directly to the company being examined for payment to
4 the Technology Management Revolving Fund.

5 (4) At the time of any service of process on the Director
6 as attorney for such service, the Director shall charge and
7 collect the sum of \$40, which may be recovered as taxable costs
8 by the party to the suit or action causing such service to be
9 made if he prevails in such suit or action.

10 (5) (a) The costs incurred by the Department of Insurance
11 in conducting any hearing authorized by law shall be assessed
12 against the parties to the hearing in such proportion as the
13 Director of Insurance may determine upon consideration of all
14 relevant circumstances including: (1) the nature of the
15 hearing; (2) whether the hearing was instigated by, or for the
16 benefit of a particular party or parties; (3) whether there is
17 a successful party on the merits of the proceeding; and (4) the
18 relative levels of participation by the parties.

19 (b) For purposes of this subsection (5) costs incurred
20 shall mean the hearing officer fees, court reporter fees, and
21 travel expenses of Department of Insurance officers and
22 employees; provided however, that costs incurred shall not
23 include hearing officer fees or court reporter fees unless the
24 Department has retained the services of independent
25 contractors or outside experts to perform such functions.

26 (c) The Director shall make the assessment of costs

1 incurred as part of the final order or decision arising out of
2 the proceeding; provided, however, that such order or decision
3 shall include findings and conclusions in support of the
4 assessment of costs. This subsection (5) shall not be
5 construed as permitting the payment of travel expenses unless
6 calculated in accordance with the applicable travel
7 regulations of the Department of Central Management Services,
8 as approved by the Governor's Travel Control Board. The
9 Director as part of such order or decision shall require all
10 assessments for hearing officer fees and court reporter fees,
11 if any, to be paid directly to the hearing officer or court
12 reporter by the party(s) assessed for such costs. The
13 assessments for travel expenses of Department officers and
14 employees shall be reimbursable to the Director of Insurance
15 for deposit to the fund out of which those expenses had been
16 paid.

17 (d) The provisions of this subsection (5) shall apply in
18 the case of any hearing conducted by the Director of Insurance
19 not otherwise specifically provided for by law.

20 (6) The Director shall charge and collect an annual
21 financial regulation fee from every domestic company for
22 examination and analysis of its financial condition and to
23 fund the internal costs and expenses of the Interstate
24 Insurance Receivership Commission as may be allocated to the
25 State of Illinois and companies doing an insurance business in
26 this State pursuant to Article X of the Interstate Insurance

1 Receivership Compact. The fee shall be the greater fixed
2 amount based upon the combination of nationwide direct premium
3 income and nationwide reinsurance assumed premium income or
4 upon admitted assets calculated under this subsection as
5 follows:

6 (a) Combination of nationwide direct premium income
7 and nationwide reinsurance assumed premium.

8 (i) \$150, if the premium is less than \$500,000 and
9 there is no reinsurance assumed premium;

10 (ii) \$750, if the premium is \$500,000 or more, but
11 less than \$5,000,000 and there is no reinsurance
12 assumed premium; or if the premium is less than
13 \$5,000,000 and the reinsurance assumed premium is less
14 than \$10,000,000;

15 (iii) \$3,750, if the premium is less than
16 \$5,000,000 and the reinsurance assumed premium is
17 \$10,000,000 or more;

18 (iv) \$7,500, if the premium is \$5,000,000 or more,
19 but less than \$10,000,000;

20 (v) \$18,000, if the premium is \$10,000,000 or
21 more, but less than \$25,000,000;

22 (vi) \$22,500, if the premium is \$25,000,000 or
23 more, but less than \$50,000,000;

24 (vii) \$30,000, if the premium is \$50,000,000 or
25 more, but less than \$100,000,000;

26 (viii) \$37,500, if the premium is \$100,000,000 or

1 more.

2 (b) Admitted assets.

3 (i) \$150, if admitted assets are less than
4 \$1,000,000;

5 (ii) \$750, if admitted assets are \$1,000,000 or
6 more, but less than \$5,000,000;

7 (iii) \$3,750, if admitted assets are \$5,000,000 or
8 more, but less than \$25,000,000;

9 (iv) \$7,500, if admitted assets are \$25,000,000 or
10 more, but less than \$50,000,000;

11 (v) \$18,000, if admitted assets are \$50,000,000 or
12 more, but less than \$100,000,000;

13 (vi) \$22,500, if admitted assets are \$100,000,000
14 or more, but less than \$500,000,000;

15 (vii) \$30,000, if admitted assets are \$500,000,000
16 or more, but less than \$1,000,000,000;

17 (viii) \$37,500, if admitted assets are
18 \$1,000,000,000 or more.

19 (c) The sum of financial regulation fees charged to
20 the domestic companies of the same affiliated group shall
21 not exceed \$250,000 in the aggregate in any single year
22 and shall be billed by the Director to the member company
23 designated by the group.

24 (7) The Director shall charge and collect an annual
25 financial regulation fee from every foreign or alien company,
26 except fraternal benefit societies, for the examination and

1 analysis of its financial condition and to fund the internal
2 costs and expenses of the Interstate Insurance Receivership
3 Commission as may be allocated to the State of Illinois and
4 companies doing an insurance business in this State pursuant
5 to Article X of the Interstate Insurance Receivership Compact.
6 The fee shall be a fixed amount based upon Illinois direct
7 premium income and nationwide reinsurance assumed premium
8 income in accordance with the following schedule:

9 (a) \$150, if the premium is less than \$500,000 and
10 there is no reinsurance assumed premium;

11 (b) \$750, if the premium is \$500,000 or more, but less
12 than \$5,000,000 and there is no reinsurance assumed
13 premium; or if the premium is less than \$5,000,000 and the
14 reinsurance assumed premium is less than \$10,000,000;

15 (c) \$3,750, if the premium is less than \$5,000,000 and
16 the reinsurance assumed premium is \$10,000,000 or more;

17 (d) \$7,500, if the premium is \$5,000,000 or more, but
18 less than \$10,000,000;

19 (e) \$18,000, if the premium is \$10,000,000 or more,
20 but less than \$25,000,000;

21 (f) \$22,500, if the premium is \$25,000,000 or more,
22 but less than \$50,000,000;

23 (g) \$30,000, if the premium is \$50,000,000 or more,
24 but less than \$100,000,000;

25 (h) \$37,500, if the premium is \$100,000,000 or more.

26 The sum of financial regulation fees under this subsection

1 (7) charged to the foreign or alien companies within the same
2 affiliated group shall not exceed \$250,000 in the aggregate in
3 any single year and shall be billed by the Director to the
4 member company designated by the group.

5 (8) Beginning January 1, 1992, the financial regulation
6 fees imposed under subsections (6) and (7) of this Section
7 shall be paid by each company or domestic affiliated group
8 annually. After January 1, 1994, the fee shall be billed by
9 Department invoice based upon the company's premium income or
10 admitted assets as shown in its annual statement for the
11 preceding calendar year. The invoice is due upon receipt and
12 must be paid no later than June 30 of each calendar year. All
13 financial regulation fees collected by the Department shall be
14 paid to the Insurance Financial Regulation Fund. The
15 Department may not collect financial examiner per diem charges
16 from companies subject to subsections (6) and (7) of this
17 Section undergoing financial examination after June 30, 1992.

18 (9) In addition to the financial regulation fee required
19 by this Section, a company undergoing any financial
20 examination authorized by law shall pay the following costs
21 and expenses incurred by the Department: electronic data
22 processing costs, the expenses authorized under Section 131.21
23 and subsection (d) of Section 132.4 of this Code, and lodging
24 and travel expenses.

25 Electronic data processing costs incurred by the
26 Department in the performance of any examination shall be

1 billed directly to the company undergoing examination for
2 payment to the Technology Management Revolving Fund. Except
3 for direct reimbursements authorized by the Director or direct
4 payments made under Section 131.21 or subsection (d) of
5 Section 132.4 of this Code, all financial regulation fees and
6 all financial examination charges collected by the Department
7 shall be paid to the Insurance Financial Regulation Fund.

8 All lodging and travel expenses shall be in accordance
9 with applicable travel regulations published by the Department
10 of Central Management Services and approved by the Governor's
11 Travel Control Board, except that out-of-state lodging and
12 travel expenses related to examinations authorized under
13 Sections 132.1 through 132.7 shall be in accordance with
14 travel rates prescribed under paragraph 301-7.2 of the Federal
15 Travel Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement
16 of subsistence expenses incurred during official travel. All
17 lodging and travel expenses may be reimbursed directly upon
18 the authorization of the Director.

19 In the case of an organization or person not subject to the
20 financial regulation fee, the expenses incurred in any
21 financial examination authorized by law shall be paid by the
22 organization or person being examined. The charge shall be
23 reasonably related to the cost of the examination including,
24 but not limited to, compensation of examiners and other costs
25 described in this subsection.

26 (10) Any company, person, or entity failing to make any

1 payment of \$150 or more as required under this Section shall be
2 subject to the penalty and interest provisions provided for in
3 subsections (4) and (7) of Section 412.

4 (11) Unless otherwise specified, all of the fees collected
5 under this Section shall be paid into the Insurance Financial
6 Regulation Fund.

7 (12) For purposes of this Section:

8 (a) "Domestic company" means a company as defined in
9 Section 2 of this Code which is incorporated or organized
10 under the laws of this State, and in addition includes a
11 not-for-profit corporation authorized under the Dental
12 Service Plan Act or the Voluntary Health Services Plans
13 Act, a health maintenance organization, and a limited
14 health service organization.

15 (b) "Foreign company" means a company as defined in
16 Section 2 of this Code which is incorporated or organized
17 under the laws of any state of the United States other than
18 this State and in addition includes a health maintenance
19 organization and a limited health service organization
20 which is incorporated or organized under the laws of any
21 state of the United States other than this State.

22 (c) "Alien company" means a company as defined in
23 Section 2 of this Code which is incorporated or organized
24 under the laws of any country other than the United
25 States.

26 (d) "Fraternal benefit society" means a corporation,

1 society, order, lodge or voluntary association as defined
2 in Section 282.1 of this Code.

3 (e) "Mutual benefit association" means a company,
4 association or corporation authorized by the Director to
5 do business in this State under the provisions of Article
6 XVIII of this Code.

7 (f) "Burial society" means a person, firm,
8 corporation, society or association of individuals
9 authorized by the Director to do business in this State
10 under the provisions of Article XIX of this Code.

11 (g) "Farm mutual" means a district, county and
12 township mutual insurance company authorized by the
13 Director to do business in this State under the provisions
14 of the Farm Mutual Insurance Company Act of 1986.

15 (Source: P.A. 102-775, eff. 5-13-22.)

16 (Text of Section after amendment by P.A. 103-75)

17 Sec. 408. Fees and charges.

18 (1) The Director shall charge, collect and give proper
19 acquittances for the payment of the following fees and
20 charges:

21 (a) For filing all documents submitted for the
22 incorporation or organization or certification of a
23 domestic company, except for a fraternal benefit society,
24 \$2,000.

25 (b) For filing all documents submitted for the

1 incorporation or organization of a fraternal benefit
2 society, \$500.

3 (c) For filing amendments to articles of incorporation
4 and amendments to declaration of organization, except for
5 a fraternal benefit society, a mutual benefit association,
6 a burial society or a farm mutual, \$200.

7 (d) For filing amendments to articles of incorporation
8 of a fraternal benefit society, a mutual benefit
9 association or a burial society, \$100.

10 (e) For filing amendments to articles of incorporation
11 of a farm mutual, \$50.

12 (f) For filing bylaws or amendments thereto, \$50.

13 (g) For filing agreement of merger or consolidation:

14 (i) for a domestic company, except for a fraternal
15 benefit society, a mutual benefit association, a
16 burial society, or a farm mutual, \$2,000.

17 (ii) for a foreign or alien company, except for a
18 fraternal benefit society, \$600.

19 (iii) for a fraternal benefit society, a mutual
20 benefit association, a burial society, or a farm
21 mutual, \$200.

22 (h) For filing agreements of reinsurance by a domestic
23 company, \$200.

24 (i) For filing all documents submitted by a foreign or
25 alien company to be admitted to transact business or
26 accredited as a reinsurer in this State, except for a

1 fraternal benefit society, \$5,000.

2 (j) For filing all documents submitted by a foreign or
3 alien fraternal benefit society to be admitted to transact
4 business in this State, \$500.

5 (k) For filing declaration of withdrawal of a foreign
6 or alien company, \$50.

7 (l) For filing annual statement by a domestic company,
8 except a fraternal benefit society, a mutual benefit
9 association, a burial society, or a farm mutual, \$200.

10 (m) For filing annual statement by a domestic
11 fraternal benefit society, \$100.

12 (n) For filing annual statement by a farm mutual, a
13 mutual benefit association, or a burial society, \$50.

14 (o) For issuing a certificate of authority or renewal
15 thereof except to a foreign fraternal benefit society,
16 \$400.

17 (p) For issuing a certificate of authority or renewal
18 thereof to a foreign fraternal benefit society, \$200.

19 (q) For issuing an amended certificate of authority,
20 \$50.

21 (r) For each certified copy of certificate of
22 authority, \$20.

23 (s) For each certificate of deposit, or valuation, or
24 compliance or surety certificate, \$20.

25 (t) For copies of papers or records per page, \$1.

26 (u) For each certification to copies of papers or

1 records, \$10.

2 (v) For multiple copies of documents or certificates
3 listed in subparagraphs (r), (s), and (u) of paragraph (1)
4 of this Section, \$10 for the first copy of a certificate of
5 any type and \$5 for each additional copy of the same
6 certificate requested at the same time, unless, pursuant
7 to paragraph (2) of this Section, the Director finds these
8 additional fees excessive.

9 (w) For issuing a permit to sell shares or increase
10 paid-up capital:

11 (i) in connection with a public stock offering,
12 \$300;

13 (ii) in any other case, \$100.

14 (x) For issuing any other certificate required or
15 permissible under the law, \$50.

16 (y) For filing a plan of exchange of the stock of a
17 domestic stock insurance company, a plan of
18 demutualization of a domestic mutual company, or a plan of
19 reorganization under Article XII, \$2,000.

20 (z) For filing a statement of acquisition of a
21 domestic company as defined in Section 131.4 of this Code,
22 \$2,000.

23 (aa) For filing an agreement to purchase the business
24 of an organization authorized under the Dental Service
25 Plan Act or the Voluntary Health Services Plans Act or of a
26 health maintenance organization or a limited health

1 service organization, \$2,000.

2 (bb) For filing a statement of acquisition of a
3 foreign or alien insurance company as defined in Section
4 131.12a of this Code, \$1,000.

5 (cc) For filing a registration statement as required
6 in Sections 131.13 and 131.14, the notification as
7 required by Sections 131.16, 131.20a, or 141.4, or an
8 agreement or transaction required by Sections 124.2(2),
9 141, 141a, or 141.1, \$200.

10 (dd) For filing an application for licensing of:

11 (i) a religious or charitable risk pooling trust
12 or a workers' compensation pool, \$1,000;

13 (ii) a workers' compensation service company,
14 \$500;

15 (iii) a self-insured automobile fleet, \$200; or

16 (iv) a renewal of or amendment of any license
17 issued pursuant to (i), (ii), or (iii) above, \$100.

18 (ee) For filing articles of incorporation for a
19 syndicate to engage in the business of insurance through
20 the Illinois Insurance Exchange, \$2,000.

21 (ff) For filing amended articles of incorporation for
22 a syndicate engaged in the business of insurance through
23 the Illinois Insurance Exchange, \$100.

24 (gg) For filing articles of incorporation for a
25 limited syndicate to join with other subscribers or
26 limited syndicates to do business through the Illinois

1 Insurance Exchange, \$1,000.

2 (hh) For filing amended articles of incorporation for
3 a limited syndicate to do business through the Illinois
4 Insurance Exchange, \$100.

5 (ii) For a permit to solicit subscriptions to a
6 syndicate or limited syndicate, \$100.

7 (jj) For the filing of each form as required in
8 Section 143 of this Code, \$50 per form. Informational and
9 advertising filings shall be \$25 per filing. The fee for
10 advisory and rating organizations shall be \$200 per form.

11 (i) For the purposes of the form filing fee,
12 filings made on insert page basis will be considered
13 one form at the time of its original submission.
14 Changes made to a form subsequent to its approval
15 shall be considered a new filing.

16 (ii) Only one fee shall be charged for a form,
17 regardless of the number of other forms or policies
18 with which it will be used.

19 (iii) Fees charged for a policy filed as it will be
20 issued regardless of the number of forms comprising
21 that policy shall not exceed \$1,500. For advisory or
22 rating organizations, fees charged for a policy filed
23 as it will be issued regardless of the number of forms
24 comprising that policy shall not exceed \$2,500.

25 (iv) The Director may by rule exempt forms from
26 such fees.

1 (kk) For filing an application for licensing of a
2 reinsurance intermediary, \$500.

3 (ll) For filing an application for renewal of a
4 license of a reinsurance intermediary, \$200.

5 (mm) For filing a plan of division of a domestic stock
6 company under Article IIB, \$100,000 ~~\$10,000~~.

7 (nn) For filing all documents submitted by a foreign
8 or alien company to be a certified reinsurer in this
9 State, except for a fraternal benefit society, \$1,000.

10 (oo) For filing a renewal by a foreign or alien
11 company to be a certified reinsurer in this State, except
12 for a fraternal benefit society, \$400.

13 (pp) For filing all documents submitted by a reinsurer
14 domiciled in a reciprocal jurisdiction, \$1,000.

15 (qq) For filing a renewal by a reinsurer domiciled in
16 a reciprocal jurisdiction, \$400.

17 (rr) For registering a captive management company or
18 renewal thereof, \$50.

19 (ss) For filing an insurance business transfer plan
20 under Article XLVII, \$100,000 ~~\$25,000~~.

21 (2) When printed copies or numerous copies of the same
22 paper or records are furnished or certified, the Director may
23 reduce such fees for copies if he finds them excessive. He may,
24 when he considers it in the public interest, furnish without
25 charge to state insurance departments and persons other than
26 companies, copies or certified copies of reports of

1 examinations and of other papers and records.

2 (3) The expenses incurred in any performance examination
3 authorized by law shall be paid by the company or person being
4 examined. The charge shall be reasonably related to the cost
5 of the examination including but not limited to compensation
6 of examiners, electronic data processing costs, supervision
7 and preparation of an examination report and lodging and
8 travel expenses. All lodging and travel expenses shall be in
9 accord with the applicable travel regulations as published by
10 the Department of Central Management Services and approved by
11 the Governor's Travel Control Board, except that out-of-state
12 lodging and travel expenses related to examinations authorized
13 under Section 132 shall be in accordance with travel rates
14 prescribed under paragraph 301-7.2 of the Federal Travel
15 Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of
16 subsistence expenses incurred during official travel. All
17 lodging and travel expenses may be reimbursed directly upon
18 authorization of the Director. With the exception of the
19 direct reimbursements authorized by the Director, all
20 performance examination charges collected by the Department
21 shall be paid to the Insurance Producer Administration Fund,
22 however, the electronic data processing costs incurred by the
23 Department in the performance of any examination shall be
24 billed directly to the company being examined for payment to
25 the Technology Management Revolving Fund.

26 (4) At the time of any service of process on the Director

1 as attorney for such service, the Director shall charge and
2 collect the sum of \$40, which may be recovered as taxable costs
3 by the party to the suit or action causing such service to be
4 made if he prevails in such suit or action.

5 (5) (a) The costs incurred by the Department of Insurance
6 in conducting any hearing authorized by law shall be assessed
7 against the parties to the hearing in such proportion as the
8 Director of Insurance may determine upon consideration of all
9 relevant circumstances including: (1) the nature of the
10 hearing; (2) whether the hearing was instigated by, or for the
11 benefit of a particular party or parties; (3) whether there is
12 a successful party on the merits of the proceeding; and (4) the
13 relative levels of participation by the parties.

14 (b) For purposes of this subsection (5) costs incurred
15 shall mean the hearing officer fees, court reporter fees, and
16 travel expenses of Department of Insurance officers and
17 employees; provided however, that costs incurred shall not
18 include hearing officer fees or court reporter fees unless the
19 Department has retained the services of independent
20 contractors or outside experts to perform such functions.

21 (c) The Director shall make the assessment of costs
22 incurred as part of the final order or decision arising out of
23 the proceeding; provided, however, that such order or decision
24 shall include findings and conclusions in support of the
25 assessment of costs. This subsection (5) shall not be
26 construed as permitting the payment of travel expenses unless

1 calculated in accordance with the applicable travel
2 regulations of the Department of Central Management Services,
3 as approved by the Governor's Travel Control Board. The
4 Director as part of such order or decision shall require all
5 assessments for hearing officer fees and court reporter fees,
6 if any, to be paid directly to the hearing officer or court
7 reporter by the party(s) assessed for such costs. The
8 assessments for travel expenses of Department officers and
9 employees shall be reimbursable to the Director of Insurance
10 for deposit to the fund out of which those expenses had been
11 paid.

12 (d) The provisions of this subsection (5) shall apply in
13 the case of any hearing conducted by the Director of Insurance
14 not otherwise specifically provided for by law.

15 (6) The Director shall charge and collect an annual
16 financial regulation fee from every domestic company for
17 examination and analysis of its financial condition and to
18 fund the internal costs and expenses of the Interstate
19 Insurance Receivership Commission as may be allocated to the
20 State of Illinois and companies doing an insurance business in
21 this State pursuant to Article X of the Interstate Insurance
22 Receivership Compact. The fee shall be the greater fixed
23 amount based upon the combination of nationwide direct premium
24 income and nationwide reinsurance assumed premium income or
25 upon admitted assets calculated under this subsection as
26 follows:

1 (a) Combination of nationwide direct premium income
2 and nationwide reinsurance assumed premium.

3 (i) \$150, if the premium is less than \$500,000 and
4 there is no reinsurance assumed premium;

5 (ii) \$750, if the premium is \$500,000 or more, but
6 less than \$5,000,000 and there is no reinsurance
7 assumed premium; or if the premium is less than
8 \$5,000,000 and the reinsurance assumed premium is less
9 than \$10,000,000;

10 (iii) \$3,750, if the premium is less than
11 \$5,000,000 and the reinsurance assumed premium is
12 \$10,000,000 or more;

13 (iv) \$7,500, if the premium is \$5,000,000 or more,
14 but less than \$10,000,000;

15 (v) \$18,000, if the premium is \$10,000,000 or
16 more, but less than \$25,000,000;

17 (vi) \$22,500, if the premium is \$25,000,000 or
18 more, but less than \$50,000,000;

19 (vii) \$30,000, if the premium is \$50,000,000 or
20 more, but less than \$100,000,000;

21 (viii) \$37,500, if the premium is \$100,000,000 or
22 more.

23 (b) Admitted assets.

24 (i) \$150, if admitted assets are less than
25 \$1,000,000;

26 (ii) \$750, if admitted assets are \$1,000,000 or

1 more, but less than \$5,000,000;

2 (iii) \$3,750, if admitted assets are \$5,000,000 or
3 more, but less than \$25,000,000;

4 (iv) \$7,500, if admitted assets are \$25,000,000 or
5 more, but less than \$50,000,000;

6 (v) \$18,000, if admitted assets are \$50,000,000 or
7 more, but less than \$100,000,000;

8 (vi) \$22,500, if admitted assets are \$100,000,000
9 or more, but less than \$500,000,000;

10 (vii) \$30,000, if admitted assets are \$500,000,000
11 or more, but less than \$1,000,000,000;

12 (viii) \$37,500, if admitted assets are
13 \$1,000,000,000 or more.

14 (c) The sum of financial regulation fees charged to
15 the domestic companies of the same affiliated group shall
16 not exceed \$250,000 in the aggregate in any single year
17 and shall be billed by the Director to the member company
18 designated by the group.

19 (7) The Director shall charge and collect an annual
20 financial regulation fee from every foreign or alien company,
21 except fraternal benefit societies, for the examination and
22 analysis of its financial condition and to fund the internal
23 costs and expenses of the Interstate Insurance Receivership
24 Commission as may be allocated to the State of Illinois and
25 companies doing an insurance business in this State pursuant
26 to Article X of the Interstate Insurance Receivership Compact.

1 The fee shall be a fixed amount based upon Illinois direct
2 premium income and nationwide reinsurance assumed premium
3 income in accordance with the following schedule:

4 (a) \$150, if the premium is less than \$500,000 and
5 there is no reinsurance assumed premium;

6 (b) \$750, if the premium is \$500,000 or more, but less
7 than \$5,000,000 and there is no reinsurance assumed
8 premium; or if the premium is less than \$5,000,000 and the
9 reinsurance assumed premium is less than \$10,000,000;

10 (c) \$3,750, if the premium is less than \$5,000,000 and
11 the reinsurance assumed premium is \$10,000,000 or more;

12 (d) \$7,500, if the premium is \$5,000,000 or more, but
13 less than \$10,000,000;

14 (e) \$18,000, if the premium is \$10,000,000 or more,
15 but less than \$25,000,000;

16 (f) \$22,500, if the premium is \$25,000,000 or more,
17 but less than \$50,000,000;

18 (g) \$30,000, if the premium is \$50,000,000 or more,
19 but less than \$100,000,000;

20 (h) \$37,500, if the premium is \$100,000,000 or more.

21 The sum of financial regulation fees under this subsection
22 (7) charged to the foreign or alien companies within the same
23 affiliated group shall not exceed \$250,000 in the aggregate in
24 any single year and shall be billed by the Director to the
25 member company designated by the group.

26 (8) Beginning January 1, 1992, the financial regulation

1 fees imposed under subsections (6) and (7) of this Section
2 shall be paid by each company or domestic affiliated group
3 annually. After January 1, 1994, the fee shall be billed by
4 Department invoice based upon the company's premium income or
5 admitted assets as shown in its annual statement for the
6 preceding calendar year. The invoice is due upon receipt and
7 must be paid no later than June 30 of each calendar year. All
8 financial regulation fees collected by the Department shall be
9 paid to the Insurance Financial Regulation Fund. The
10 Department may not collect financial examiner per diem charges
11 from companies subject to subsections (6) and (7) of this
12 Section undergoing financial examination after June 30, 1992.

13 (9) In addition to the financial regulation fee required
14 by this Section, a company undergoing any financial
15 examination authorized by law shall pay the following costs
16 and expenses incurred by the Department: electronic data
17 processing costs, the expenses authorized under Section 131.21
18 and subsection (d) of Section 132.4 of this Code, and lodging
19 and travel expenses.

20 Electronic data processing costs incurred by the
21 Department in the performance of any examination shall be
22 billed directly to the company undergoing examination for
23 payment to the Technology Management Revolving Fund. Except
24 for direct reimbursements authorized by the Director or direct
25 payments made under Section 131.21 or subsection (d) of
26 Section 132.4 of this Code, all financial regulation fees and

1 all financial examination charges collected by the Department
2 shall be paid to the Insurance Financial Regulation Fund.

3 All lodging and travel expenses shall be in accordance
4 with applicable travel regulations published by the Department
5 of Central Management Services and approved by the Governor's
6 Travel Control Board, except that out-of-state lodging and
7 travel expenses related to examinations authorized under
8 Sections 132.1 through 132.7 shall be in accordance with
9 travel rates prescribed under paragraph 301-7.2 of the Federal
10 Travel Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement
11 of subsistence expenses incurred during official travel. All
12 lodging and travel expenses may be reimbursed directly upon
13 the authorization of the Director.

14 In the case of an organization or person not subject to the
15 financial regulation fee, the expenses incurred in any
16 financial examination authorized by law shall be paid by the
17 organization or person being examined. The charge shall be
18 reasonably related to the cost of the examination including,
19 but not limited to, compensation of examiners and other costs
20 described in this subsection.

21 (10) Any company, person, or entity failing to make any
22 payment of \$150 or more as required under this Section shall be
23 subject to the penalty and interest provisions provided for in
24 subsections (4) and (7) of Section 412.

25 (11) Unless otherwise specified, all of the fees collected
26 under this Section shall be paid into the Insurance Financial

1 Regulation Fund.

2 (12) For purposes of this Section:

3 (a) "Domestic company" means a company as defined in
4 Section 2 of this Code which is incorporated or organized
5 under the laws of this State, and in addition includes a
6 not-for-profit corporation authorized under the Dental
7 Service Plan Act or the Voluntary Health Services Plans
8 Act, a health maintenance organization, and a limited
9 health service organization.

10 (b) "Foreign company" means a company as defined in
11 Section 2 of this Code which is incorporated or organized
12 under the laws of any state of the United States other than
13 this State and in addition includes a health maintenance
14 organization and a limited health service organization
15 which is incorporated or organized under the laws of any
16 state of the United States other than this State.

17 (c) "Alien company" means a company as defined in
18 Section 2 of this Code which is incorporated or organized
19 under the laws of any country other than the United
20 States.

21 (d) "Fraternal benefit society" means a corporation,
22 society, order, lodge or voluntary association as defined
23 in Section 282.1 of this Code.

24 (e) "Mutual benefit association" means a company,
25 association or corporation authorized by the Director to
26 do business in this State under the provisions of Article

1 XVIII of this Code.

2 (f) "Burial society" means a person, firm,
3 corporation, society or association of individuals
4 authorized by the Director to do business in this State
5 under the provisions of Article XIX of this Code.

6 (g) "Farm mutual" means a district, county and
7 township mutual insurance company authorized by the
8 Director to do business in this State under the provisions
9 of the Farm Mutual Insurance Company Act of 1986.

10 (Source: P.A. 102-775, eff. 5-13-22; 103-75, eff. 1-1-25.)

11 (215 ILCS 5/412) (from Ch. 73, par. 1024)

12 Sec. 412. Refunds; penalties; collection.

13 (1) (a) Whenever it appears to the satisfaction of the
14 Director that because of some mistake of fact, error in
15 calculation, or erroneous interpretation of a statute of this
16 or any other state, any authorized company, surplus line
17 producer, or industrial insured has paid to him, pursuant to
18 any provision of law, taxes, fees, or other charges in excess
19 of the amount legally chargeable against it, during the 6-year
20 ~~6-year~~ period immediately preceding the discovery of such
21 overpayment, he shall have power to refund to such company,
22 surplus line producer, or industrial insured the amount of the
23 excess or excesses by applying the amount or amounts thereof
24 toward the payment of taxes, fees, or other charges already
25 due, or which may thereafter become due from that company

1 until such excess or excesses have been fully refunded, or
2 upon a written request from the authorized company, surplus
3 line producer, or industrial insured, the Director shall
4 provide a cash refund within 120 days after receipt of the
5 written request if all necessary information has been filed
6 with the Department in order for it to perform an audit of the
7 tax report for the transaction or period or annual return for
8 the year in which the overpayment occurred or within 120 days
9 after the date the Department receives all the necessary
10 information to perform such audit. The Director shall not
11 provide a cash refund if there are insufficient funds in the
12 Insurance Premium Tax Refund Fund to provide a cash refund, if
13 the amount of the overpayment is less than \$100, or if the
14 amount of the overpayment can be fully offset against the
15 taxpayer's estimated liability for the year following the year
16 of the cash refund request. Any cash refund shall be paid from
17 the Insurance Premium Tax Refund Fund, a special fund hereby
18 created in the State treasury.

19 (b) As determined by the Director pursuant to paragraph
20 (a) of this subsection, the Department shall deposit an amount
21 of cash refunds approved by the Director for payment as a
22 result of overpayment of tax liability collected under
23 Sections 121-2.08, 409, 444, 444.1, and 445 of this Code into
24 the Insurance Premium Tax Refund Fund.

25 (c) Beginning July 1, 1999, moneys in the Insurance
26 Premium Tax Refund Fund shall be expended exclusively for the

1 purpose of paying cash refunds resulting from overpayment of
2 tax liability under Sections 121-2.08, 409, 444, 444.1, and
3 445 of this Code as determined by the Director pursuant to
4 subsection 1(a) of this Section. Cash refunds made in
5 accordance with this Section may be made from the Insurance
6 Premium Tax Refund Fund only to the extent that amounts have
7 been deposited and retained in the Insurance Premium Tax
8 Refund Fund.

9 (d) This Section shall constitute an irrevocable and
10 continuing appropriation from the Insurance Premium Tax Refund
11 Fund for the purpose of paying cash refunds pursuant to the
12 provisions of this Section.

13 (2)(a) When any insurance company fails to file any tax
14 return required under Sections 408.1, 409, 444, and 444.1 of
15 this Code or Section 12 of the Fire Investigation Act on the
16 date prescribed, including any extensions, there shall be
17 added as a penalty \$400 or 10% of the amount of such tax,
18 whichever is greater, for each month or part of a month of
19 failure to file, the entire penalty not to exceed \$2,000 or 50%
20 of the tax due, whichever is greater. In this paragraph, "tax
21 due" means the full amount due for the applicable tax period
22 under Section 408.1, 409, 444, or 444.1 of this Code or Section
23 12 of the Fire Investigation Act.

24 (b) When any industrial insured or surplus line producer
25 fails to file any tax return or report required under Sections
26 121-2.08 and 445 of this Code or Section 12 of the Fire

1 Investigation Act on the date prescribed, including any
2 extensions, there shall be added:

3 (i) as a late fee, if the return or report is received
4 at least one day but not more than 15 days after the
5 prescribed due date, \$50 or 5% of the tax due, whichever is
6 greater, the entire fee not to exceed \$1,000;

7 (ii) as a late fee, if the return or report is received
8 at least 16 days but not more than 30 days after the
9 prescribed due date, \$100 or 5% of the tax due, whichever
10 is greater, the entire fee not to exceed \$2,000; or

11 (iii) as a penalty, if the return or report is
12 received more than 30 days after the prescribed due date,
13 \$100 or 5% of the tax due, whichever is greater, for each
14 month or part of a month of failure to file, the entire
15 penalty not to exceed \$500 or 30% of the tax due, whichever
16 is greater.

17 In this paragraph, "tax due" means the full amount due for
18 the applicable tax period under Section 121-2.08 or 445 of
19 this Code or Section 12 of the Fire Investigation Act. A tax
20 return or report shall be deemed received as of the date mailed
21 as evidenced by a postmark, proof of mailing on a recognized
22 United States Postal Service form or a form acceptable to the
23 United States Postal Service or other commercial mail delivery
24 service, or other evidence acceptable to the Director.

25 (3) (a) When any insurance company fails to pay the full
26 amount due under the provisions of this Section, Sections

1 408.1, 409, 444, or 444.1 of this Code, or Section 12 of the
2 Fire Investigation Act, there shall be added to the amount due
3 as a penalty an amount equal to 10% of the deficiency.

4 (a-5) When any industrial insured or surplus line producer
5 fails to pay the full amount due under the provisions of this
6 Section, Sections 121-2.08 or 445 of this Code, or Section 12
7 of the Fire Investigation Act on the date prescribed, there
8 shall be added:

9 (i) as a late fee, if the payment is received at least
10 one day but not more than 7 days after the prescribed due
11 date, 10% of the tax due, the entire fee not to exceed
12 \$1,000;

13 (ii) as a late fee, if the payment is received at least
14 8 days but not more than 14 days after the prescribed due
15 date, 10% of the tax due, the entire fee not to exceed
16 \$1,500;

17 (iii) as a late fee, if the payment is received at
18 least 15 days but not more than 21 days after the
19 prescribed due date, 10% of the tax due, the entire fee not
20 to exceed \$2,000; or

21 (iv) as a penalty, if the return or report is received
22 more than 21 days after the prescribed due date, 10% of the
23 tax due.

24 In this paragraph, "tax due" means the full amount due for
25 the applicable tax period under this Section, Section 121-2.08
26 or 445 of this Code, or Section 12 of the Fire Investigation

1 Act. A tax payment shall be deemed received as of the date
2 mailed as evidenced by a postmark, proof of mailing on a
3 recognized United States Postal Service form or a form
4 acceptable to the United States Postal Service or other
5 commercial mail delivery service, or other evidence acceptable
6 to the Director.

7 (b) If such failure to pay is determined by the Director to
8 be willful ~~willful~~, after a hearing under Sections 402 and 403,
9 there shall be added to the tax as a penalty an amount equal to
10 the greater of 50% of the deficiency or 10% of the amount due
11 and unpaid for each month or part of a month that the
12 deficiency remains unpaid commencing with the date that the
13 amount becomes due. Such amount shall be in lieu of any
14 determined under paragraph (a) or (a-5).

15 (4) Any insurance company, industrial insured, or surplus
16 line producer that fails to pay the full amount due under this
17 Section or Sections 121-2.08, 408.1, 409, 444, 444.1, or 445
18 of this Code, or Section 12 of the Fire Investigation Act is
19 liable, in addition to the tax and any late fees and penalties,
20 for interest on such deficiency at the rate of 12% per annum,
21 or at such higher adjusted rates as are or may be established
22 under subsection (b) of Section 6621 of the Internal Revenue
23 Code, from the date that payment of any such tax was due,
24 determined without regard to any extensions, to the date of
25 payment of such amount.

26 (5) The Director, through the Attorney General, may

1 institute an action in the name of the People of the State of
2 Illinois, in any court of competent jurisdiction, for the
3 recovery of the amount of such taxes, fees, and penalties due,
4 and prosecute the same to final judgment, and take such steps
5 as are necessary to collect the same.

6 (6) In the event that the certificate of authority of a
7 foreign or alien company is revoked for any cause or the
8 company withdraws from this State prior to the renewal date of
9 the certificate of authority as provided in Section 114, the
10 company may recover the amount of any such tax paid in advance.
11 Except as provided in this subsection, no revocation or
12 withdrawal excuses payment of or constitutes grounds for the
13 recovery of any taxes or penalties imposed by this Code.

14 (7) When an insurance company or domestic affiliated group
15 fails to pay the full amount of any fee of \$200 or more due
16 under Section 408 of this Code, there shall be added to the
17 amount due as a penalty the greater of \$100 or an amount equal
18 to 10% of the deficiency for each month or part of a month that
19 the deficiency remains unpaid.

20 (8) The Department shall have a lien for the taxes, fees,
21 charges, fines, penalties, interest, other charges, or any
22 portion thereof, imposed or assessed pursuant to this Code,
23 upon all the real and personal property of any company or
24 person to whom the assessment or final order has been issued or
25 whenever a tax return is filed without payment of the tax or
26 penalty shown therein to be due, including all such property

1 of the company or person acquired after receipt of the
2 assessment, issuance of the order, or filing of the return.
3 The company or person is liable for the filing fee incurred by
4 the Department for filing the lien and the filing fee incurred
5 by the Department to file the release of that lien. The filing
6 fees shall be paid to the Department in addition to payment of
7 the tax, fee, charge, fine, penalty, interest, other charges,
8 or any portion thereof, included in the amount of the lien.
9 However, where the lien arises because of the issuance of a
10 final order of the Director or tax assessment by the
11 Department, the lien shall not attach and the notice referred
12 to in this Section shall not be filed until all administrative
13 proceedings or proceedings in court for review of the final
14 order or assessment have terminated or the time for the taking
15 thereof has expired without such proceedings being instituted.

16 Upon the granting of Department review after a lien has
17 attached, the lien shall remain in full force except to the
18 extent to which the final assessment may be reduced by a
19 revised final assessment following the rehearing or review.
20 The lien created by the issuance of a final assessment shall
21 terminate, unless a notice of lien is filed, within 3 years
22 after the date all proceedings in court for the review of the
23 final assessment have terminated or the time for the taking
24 thereof has expired without such proceedings being instituted,
25 or (in the case of a revised final assessment issued pursuant
26 to a rehearing or review by the Department) within 3 years

1 after the date all proceedings in court for the review of such
2 revised final assessment have terminated or the time for the
3 taking thereof has expired without such proceedings being
4 instituted. Where the lien results from the filing of a tax
5 return without payment of the tax or penalty shown therein to
6 be due, the lien shall terminate, unless a notice of lien is
7 filed, within 3 years after the date when the return is filed
8 with the Department.

9 The time limitation period on the Department's right to
10 file a notice of lien shall not run during any period of time
11 in which the order of any court has the effect of enjoining or
12 restraining the Department from filing such notice of lien. If
13 the Department finds that a company or person is about to
14 depart from the State, to conceal himself or his property, or
15 to do any other act tending to prejudice or to render wholly or
16 partly ineffectual proceedings to collect the amount due and
17 owing to the Department unless such proceedings are brought
18 without delay, or if the Department finds that the collection
19 of the amount due from any company or person will be
20 jeopardized by delay, the Department shall give the company or
21 person notice of such findings and shall make demand for
22 immediate return and payment of the amount, whereupon the
23 amount shall become immediately due and payable. If the
24 company or person, within 5 days after the notice (or within
25 such extension of time as the Department may grant), does not
26 comply with the notice or show to the Department that the

1 findings in the notice are erroneous, the Department may file
2 a notice of jeopardy assessment lien in the office of the
3 recorder of the county in which any property of the company or
4 person may be located and shall notify the company or person of
5 the filing. The jeopardy assessment lien shall have the same
6 scope and effect as the statutory lien provided for in this
7 Section. If the company or person believes that the company or
8 person does not owe some or all of the tax for which the
9 jeopardy assessment lien against the company or person has
10 been filed, or that no jeopardy to the revenue in fact exists,
11 the company or person may protest within 20 days after being
12 notified by the Department of the filing of the jeopardy
13 assessment lien and request a hearing, whereupon the
14 Department shall hold a hearing in conformity with the
15 provisions of this Code and, pursuant thereto, shall notify
16 the company or person of its findings as to whether or not the
17 jeopardy assessment lien will be released. If not, and if the
18 company or person is aggrieved by this decision, the company
19 or person may file an action for judicial review of the final
20 determination of the Department in accordance with the
21 Administrative Review Law. If, pursuant to such hearing (or
22 after an independent determination of the facts by the
23 Department without a hearing), the Department determines that
24 some or all of the amount due covered by the jeopardy
25 assessment lien is not owed by the company or person, or that
26 no jeopardy to the revenue exists, or if on judicial review the

1 final judgment of the court is that the company or person does
2 not owe some or all of the amount due covered by the jeopardy
3 assessment lien against them, or that no jeopardy to the
4 revenue exists, the Department shall release its jeopardy
5 assessment lien to the extent of such finding of nonliability
6 for the amount, or to the extent of such finding of no jeopardy
7 to the revenue. The Department shall also release its jeopardy
8 assessment lien against the company or person whenever the
9 amount due and owing covered by the lien, plus any interest
10 which may be due, are paid and the company or person has paid
11 the Department in cash or by guaranteed remittance an amount
12 representing the filing fee for the lien and the filing fee for
13 the release of that lien. The Department shall file that
14 release of lien with the recorder of the county where that lien
15 was filed.

16 Nothing in this Section shall be construed to give the
17 Department a preference over the rights of any bona fide
18 purchaser, holder of a security interest, mechanics
19 lienholder, mortgagee, or judgment lien creditor arising prior
20 to the filing of a regular notice of lien or a notice of
21 jeopardy assessment lien in the office of the recorder in the
22 county in which the property subject to the lien is located.
23 For purposes of this Section, "bona fide" shall not include
24 any mortgage of real or personal property or any other credit
25 transaction that results in the mortgagee or the holder of the
26 security acting as trustee for unsecured creditors of the

1 company or person mentioned in the notice of lien who executed
2 such chattel or real property mortgage or the document
3 evidencing such credit transaction. The lien shall be inferior
4 to the lien of general taxes, special assessments, and special
5 taxes levied by any political subdivision of this State. In
6 case title to land to be affected by the notice of lien or
7 notice of jeopardy assessment lien is registered under the
8 provisions of the Registered Titles (Torrens) Act, such notice
9 shall be filed in the office of the Registrar of Titles of the
10 county within which the property subject to the lien is
11 situated and shall be entered upon the register of titles as a
12 memorial or charge upon each folium of the register of titles
13 affected by such notice, and the Department shall not have a
14 preference over the rights of any bona fide purchaser,
15 mortgagee, judgment creditor, or other lienholder arising
16 prior to the registration of such notice. The regular lien or
17 jeopardy assessment lien shall not be effective against any
18 purchaser with respect to any item in a retailer's stock in
19 trade purchased from the retailer in the usual course of the
20 retailer's business.

21 (Source: P.A. 102-775, eff. 5-13-22; 103-426, eff. 8-4-23.)

22 (215 ILCS 5/531.03) (from Ch. 73, par. 1065.80-3)

23 Sec. 531.03. Coverage and limitations.

24 (1) This Article shall provide coverage for the policies
25 and contracts specified in subsection (2) of this Section:

1 (a) to persons who, regardless of where they reside
2 (except for non-resident certificate holders under group
3 policies or contracts), are the beneficiaries, assignees
4 or payees, including health care providers rendering
5 services covered under a health insurance policy or
6 certificate, of the persons covered under paragraph (b) of
7 this subsection, and

8 (b) to persons who are owners of or certificate
9 holders or enrollees under the policies or contracts
10 (other than unallocated annuity contracts and structured
11 settlement annuities) and in each case who:

12 (i) are residents; or

13 (ii) are not residents, but only under all of the
14 following conditions:

15 (A) the member insurer that issued the
16 policies or contracts is domiciled in this State;

17 (B) the states in which the persons reside
18 have associations similar to the Association
19 created by this Article;

20 (C) the persons are not eligible for coverage
21 by an association in any other state due to the
22 fact that the insurer or health maintenance
23 organization was not licensed in that state at the
24 time specified in that state's guaranty
25 association law.

26 (c) For unallocated annuity contracts specified in

1 subsection (2), paragraphs (a) and (b) of this subsection
2 (1) shall not apply and this Article shall (except as
3 provided in paragraphs (e) and (f) of this subsection)
4 provide coverage to:

5 (i) persons who are the owners of the unallocated
6 annuity contracts if the contracts are issued to or in
7 connection with a specific benefit plan whose plan
8 sponsor has its principal place of business in this
9 State; and

10 (ii) persons who are owners of unallocated annuity
11 contracts issued to or in connection with government
12 lotteries if the owners are residents.

13 (d) For structured settlement annuities specified in
14 subsection (2), paragraphs (a) and (b) of this subsection
15 (1) shall not apply and this Article shall (except as
16 provided in paragraphs (e) and (f) of this subsection)
17 provide coverage to a person who is a payee under a
18 structured settlement annuity (or beneficiary of a payee
19 if the payee is deceased), if the payee:

20 (i) is a resident, regardless of where the
21 contract owner resides; or

22 (ii) is not a resident, but only under both of the
23 following conditions:

24 (A) with regard to residency:

25 (I) the contract owner of the structured
26 settlement annuity is a resident; or

1 (II) the contract owner of the structured
2 settlement annuity is not a resident but the
3 insurer that issued the structured settlement
4 annuity is domiciled in this State and the
5 state in which the contract owner resides has
6 an association similar to the Association
7 created by this Article; and

8 (B) neither the payee or beneficiary nor the
9 contract owner is eligible for coverage by the
10 association of the state in which the payee or
11 contract owner resides.

12 (e) This Article shall not provide coverage to:

13 (i) a person who is a payee or beneficiary of a
14 contract owner resident of this State if the payee or
15 beneficiary is afforded any coverage by the
16 association of another state; or

17 (ii) a person covered under paragraph (c) of this
18 subsection (1), if any coverage is provided by the
19 association of another state to that person.

20 (f) This Article is intended to provide coverage to a
21 person who is a resident of this State and, in special
22 circumstances, to a nonresident. In order to avoid
23 duplicate coverage, if a person who would otherwise
24 receive coverage under this Article is provided coverage
25 under the laws of any other state, then the person shall
26 not be provided coverage under this Article. In

1 determining the application of the provisions of this
2 paragraph in situations where a person could be covered by
3 the association of more than one state, whether as an
4 owner, payee, enrollee, beneficiary, or assignee, this
5 Article shall be construed in conjunction with other state
6 laws to result in coverage by only one association.

7 (2) (a) This Article shall provide coverage to the persons
8 specified in subsection (1) of this Section for policies or
9 contracts of direct, (i) nongroup life insurance, health
10 insurance (that, for the purposes of this Article, includes
11 health maintenance organization subscriber contracts and
12 certificates), annuities and supplemental contracts to any of
13 these, (ii) for certificates under direct group policies or
14 contracts, (iii) for unallocated annuity contracts and (iv)
15 for contracts to furnish health care services and subscription
16 certificates for medical or health care services issued by
17 persons licensed to transact insurance business in this State
18 under this Code. Annuity contracts and certificates under
19 group annuity contracts include but are not limited to
20 guaranteed investment contracts, deposit administration
21 contracts, unallocated funding agreements, allocated funding
22 agreements, structured settlement agreements, lottery
23 contracts and any immediate or deferred annuity contracts.

24 (b) Except as otherwise provided in paragraph (c) of this
25 subsection, this Article shall not provide coverage for:

26 (i) that portion of a policy or contract not

1 guaranteed by the member insurer, or under which the risk
2 is borne by the policy or contract owner;

3 (ii) any such policy or contract or part thereof
4 assumed by the impaired or insolvent insurer under a
5 contract of reinsurance, other than reinsurance for which
6 assumption certificates have been issued;

7 (iii) any portion of a policy or contract to the
8 extent that the rate of interest on which it is based or
9 the interest rate, crediting rate, or similar factor is
10 determined by use of an index or other external reference
11 stated in the policy or contract employed in calculating
12 returns or changes in value:

13 (A) averaged over the period of 4 years prior to
14 the date on which the member insurer becomes an
15 impaired or insolvent insurer under this Article,
16 whichever is earlier, exceeds the rate of interest
17 determined by subtracting 2 percentage points from
18 Moody's Corporate Bond Yield Average averaged for that
19 same 4-year period or for such lesser period if the
20 policy or contract was issued less than 4 years before
21 the member insurer becomes an impaired or insolvent
22 insurer under this Article, whichever is earlier; and

23 (B) on and after the date on which the member
24 insurer becomes an impaired or insolvent insurer under
25 this Article, whichever is earlier, exceeds the rate
26 of interest determined by subtracting 3 percentage

1 points from Moody's Corporate Bond Yield Average as
2 most recently available;

3 (iv) any unallocated annuity contract issued to or in
4 connection with a benefit plan protected under the federal
5 Pension Benefit Guaranty Corporation, regardless of
6 whether the federal Pension Benefit Guaranty Corporation
7 has yet become liable to make any payments with respect to
8 the benefit plan;

9 (v) any portion of any unallocated annuity contract
10 which is not issued to or in connection with a specific
11 employee, union or association of natural persons benefit
12 plan or a government lottery;

13 (vi) an obligation that does not arise under the
14 express written terms of the policy or contract issued by
15 the member insurer to the enrollee, certificate holder,
16 contract owner, or policy owner, including without
17 limitation:

18 (A) a claim based on marketing materials;

19 (B) a claim based on side letters, riders, or
20 other documents that were issued by the member insurer
21 without meeting applicable policy or contract form
22 filing or approval requirements;

23 (C) a misrepresentation of or regarding policy or
24 contract benefits;

25 (D) an extra-contractual claim; or

26 (E) a claim for penalties or consequential or

1 incidental damages;

2 (vii) any stop-loss insurance, as defined in clause
3 (b) of Class 1 or clause (a) of Class 2 of Section 4, ~~and~~
4 ~~further defined in subsection (d) of Section 352;~~

5 (viii) any policy or contract providing any hospital,
6 medical, prescription drug, or other health care benefits
7 pursuant to Part C or Part D of Subchapter XVIII, Chapter 7
8 of Title 42 of the United States Code (commonly known as
9 Medicare Part C & D), Subchapter XIX, Chapter 7 of Title 42
10 of the United States Code (commonly known as Medicaid), or
11 any regulations issued pursuant thereto;

12 (ix) any portion of a policy or contract to the extent
13 that the assessments required by Section 531.09 of this
14 Code with respect to the policy or contract are preempted
15 or otherwise not permitted by federal or State law;

16 (x) any portion of a policy or contract issued to a
17 plan or program of an employer, association, or other
18 person to provide life, health, or annuity benefits to its
19 employees, members, or others to the extent that the plan
20 or program is self-funded or uninsured, including, but not
21 limited to, benefits payable by an employer, association,
22 or other person under:

23 (A) a multiple employer welfare arrangement as
24 defined in 29 U.S.C. Section 1002;

25 (B) a minimum premium group insurance plan;

26 (C) a stop-loss group insurance plan; or

- 1 (D) an administrative services only contract;
- 2 (xi) any portion of a policy or contract to the extent
3 that it provides for:
- 4 (A) dividends or experience rating credits;
- 5 (B) voting rights; or
- 6 (C) payment of any fees or allowances to any
7 person, including the policy or contract owner, in
8 connection with the service to or administration of
9 the policy or contract;
- 10 (xii) any policy or contract issued in this State by a
11 member insurer at a time when it was not licensed or did
12 not have a certificate of authority to issue the policy or
13 contract in this State;
- 14 (xiii) any contractual agreement that establishes the
15 member insurer's obligations to provide a book value
16 accounting guaranty for defined contribution benefit plan
17 participants by reference to a portfolio of assets that is
18 owned by the benefit plan or its trustee, which in each
19 case is not an affiliate of the member insurer;
- 20 (xiv) any portion of a policy or contract to the
21 extent that it provides for interest or other changes in
22 value to be determined by the use of an index or other
23 external reference stated in the policy or contract, but
24 which have not been credited to the policy or contract, or
25 as to which the policy or contract owner's rights are
26 subject to forfeiture, as of the date the member insurer

1 becomes an impaired or insolvent insurer under this Code,
2 whichever is earlier. If a policy's or contract's interest
3 or changes in value are credited less frequently than
4 annually, then for purposes of determining the values that
5 have been credited and are not subject to forfeiture under
6 this Section, the interest or change in value determined
7 by using the procedures defined in the policy or contract
8 will be credited as if the contractual date of crediting
9 interest or changing values was the date of impairment or
10 insolvency, whichever is earlier, and will not be subject
11 to forfeiture; or

12 (xv) that portion or part of a variable life insurance
13 or variable annuity contract not guaranteed by a member
14 insurer.

15 (c) The exclusion from coverage referenced in subdivision
16 (iii) of paragraph (b) of this subsection shall not apply to
17 any portion of a policy or contract, including a rider, that
18 provides long-term care or other health insurance benefits.

19 (3) The benefits for which the Association may become
20 liable shall in no event exceed the lesser of:

21 (a) the contractual obligations for which the member
22 insurer is liable or would have been liable if it were not
23 an impaired or insolvent insurer, or

24 (b) (i) with respect to any one life, regardless of the
25 number of policies or contracts:

26 (A) \$300,000 in life insurance death benefits, but

1 not more than \$100,000 in net cash surrender and net
2 cash withdrawal values for life insurance;

3 (B) for health insurance benefits:

4 (I) \$100,000 for coverages not defined as
5 disability income insurance or health benefit
6 plans or long-term care insurance, including any
7 net cash surrender and net cash withdrawal values;

8 (II) \$300,000 for disability income insurance
9 and \$300,000 for long-term care insurance; and

10 (III) \$500,000 for health benefit plans;

11 (C) \$250,000 in the present value of annuity
12 benefits, including net cash surrender and net cash
13 withdrawal values;

14 (ii) with respect to each individual participating in
15 a governmental retirement benefit plan established under
16 Section 401, 403(b), or 457 of the U.S. Internal Revenue
17 Code covered by an unallocated annuity contract or the
18 beneficiaries of each such individual if deceased, in the
19 aggregate, \$250,000 in present value annuity benefits,
20 including net cash surrender and net cash withdrawal
21 values;

22 (iii) with respect to each payee of a structured
23 settlement annuity or beneficiary or beneficiaries of the
24 payee if deceased, \$250,000 in present value annuity
25 benefits, in the aggregate, including net cash surrender
26 and net cash withdrawal values, if any; or

1 (iv) with respect to either (1) one contract owner
2 provided coverage under subparagraph (ii) of paragraph (c)
3 of subsection (1) of this Section or (2) one plan sponsor
4 whose plans own directly or in trust one or more
5 unallocated annuity contracts not included in subparagraph
6 (ii) of paragraph (b) of this subsection, \$5,000,000 in
7 benefits, irrespective of the number of contracts with
8 respect to the contract owner or plan sponsor. However, in
9 the case where one or more unallocated annuity contracts
10 are covered contracts under this Article and are owned by
11 a trust or other entity for the benefit of 2 or more plan
12 sponsors, coverage shall be afforded by the Association if
13 the largest interest in the trust or entity owning the
14 contract or contracts is held by a plan sponsor whose
15 principal place of business is in this State. In no event
16 shall the Association be obligated to cover more than
17 \$5,000,000 in benefits with respect to all these
18 unallocated contracts.

19 In no event shall the Association be obligated to cover
20 more than (1) an aggregate of \$300,000 in benefits with
21 respect to any one life under subparagraphs (i), (ii), and
22 (iii) of this paragraph (b) except with respect to benefits
23 for health benefit plans under item (B) of subparagraph (i) of
24 this paragraph (b), in which case the aggregate liability of
25 the Association shall not exceed \$500,000 with respect to any
26 one individual or (2) with respect to one owner of multiple

1 nongroup policies of life insurance, whether the policy or
2 contract owner is an individual, firm, corporation, or other
3 person and whether the persons insured are officers, managers,
4 employees, or other persons, \$5,000,000 in benefits,
5 regardless of the number of policies and contracts held by the
6 owner.

7 The limitations set forth in this subsection are
8 limitations on the benefits for which the Association is
9 obligated before taking into account either its subrogation
10 and assignment rights or the extent to which those benefits
11 could be provided out of the assets of the impaired or
12 insolvent insurer attributable to covered policies. The costs
13 of the Association's obligations under this Article may be met
14 by the use of assets attributable to covered policies or
15 reimbursed to the Association pursuant to its subrogation and
16 assignment rights.

17 For purposes of this Article, benefits provided by a
18 long-term care rider to a life insurance policy or annuity
19 contract shall be considered the same type of benefits as the
20 base life insurance policy or annuity contract to which it
21 relates.

22 (4) In performing its obligations to provide coverage
23 under Section 531.08 of this Code, the Association shall not
24 be required to guarantee, assume, reinsure, reissue, or
25 perform or cause to be guaranteed, assumed, reinsured,
26 reissued, or performed the contractual obligations of the

1 insolvent or impaired insurer under a covered policy or
2 contract that do not materially affect the economic values or
3 economic benefits of the covered policy or contract.

4 (Source: P.A. 100-687, eff. 8-3-18; 100-863, eff. 8-14-18.)

5 (215 ILCS 5/356z.30a rep.)

6 (215 ILCS 5/362a rep.)

7 Section 26. The Illinois Insurance Code is amended by
8 repealing Sections 356z.30a and 362a.

9 Section 30. The Network Adequacy and Transparency Act is
10 amended by changing Sections 5 and 10 as follows:

11 (215 ILCS 124/5)

12 Sec. 5. Definitions. In this Act:

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

19 "Beneficiary" means an individual, an enrollee, an
20 insured, a participant, or any other person entitled to
21 reimbursement for covered expenses of or the discounting of
22 provider fees for health care services under a program in
23 which the beneficiary has an incentive to utilize the services

1 of a provider that has entered into an agreement or
2 arrangement with an insurer.

3 "Department" means the Department of Insurance.

4 "Director" means the Director of Insurance.

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

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

19 "Material change" means a significant reduction in the
20 number of providers available in a network plan, including,
21 but not limited to, a reduction of 10% or more in a specific
22 type of providers, the removal of a major health system that
23 causes a network to be significantly different from the
24 network when the beneficiary purchased the network plan, or
25 any change that would cause the network to no longer satisfy
26 the requirements of this Act or the Department's rules for

1 network adequacy and transparency.

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

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

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

21 "Preferred provider" means any provider who has entered,
22 either directly or indirectly, into an agreement with an
23 employer or risk-bearing entity relating to health care
24 services that may be rendered to beneficiaries under a network
25 plan.

26 "Providers" means physicians licensed to practice medicine

1 in all its branches, other health care professionals,
2 hospitals, or other health care institutions that provide
3 health care services.

4 "Telehealth" has the meaning given to that term in Section
5 356z.22 of the Illinois Insurance Code.

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

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

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

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

17 (215 ILCS 124/10)

18 Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

26 (3) The number of beneficiaries anticipated to be

1 covered by the network plan.

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

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

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

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

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

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

25 (6) A provision ensuring that whenever a beneficiary
26 has made a good faith effort, as evidenced by accessing

1 the provider directory, calling the network plan, and
2 calling the provider, to utilize preferred providers for a
3 covered service and it is determined the insurer does not
4 have the appropriate preferred providers due to
5 insufficient number, type, unreasonable travel distance or
6 delay, or preferred providers refusing to provide a
7 covered service because it is contrary to the conscience
8 of the preferred providers, as protected by the Health
9 Care Right of Conscience Act, the insurer shall ensure,
10 directly or indirectly, by terms contained in the payer
11 contract, that the beneficiary will be provided the
12 covered service at no greater cost to the beneficiary than
13 if the service had been provided by a preferred provider.
14 This paragraph (6) does not apply to: (A) a beneficiary
15 who willfully chooses to access a non-preferred provider
16 for health care services available through the panel of
17 preferred providers, or (B) a beneficiary enrolled in a
18 health maintenance organization. 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 ~~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 (2) The Director shall establish a process for the
9 review of the adequacy of these standards, along with an
10 assessment of additional specialties to be included in the
11 list under this subsection (c).

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

21 The maximum travel time and distance standards must
22 include standards for each physician and other provider
23 category listed for which ratios have been established.

24 The Director shall establish a process for the review of
25 the adequacy of these standards along with an assessment of
26 additional specialties to be included in the list under this

1 subsection (d).

2 (d-5)(1) Every insurer shall ensure that beneficiaries
3 have 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 Insurers 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 insurer 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.

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.)

22 Section 35. The Health Maintenance Organization Act is
23 amended by changing Sections 4.5-1, 5-3, and 5-3.1 as follows:

24 (215 ILCS 125/4.5-1)

1 Sec. 4.5-1. Point-of-service health service contracts.

2 (a) A health maintenance organization that offers a
3 point-of-service contract:

4 (1) must include as in-plan covered services all
5 services required by law to be provided by a health
6 maintenance organization;

7 (2) must provide incentives, which shall include
8 financial incentives, for enrollees to use in-plan covered
9 services;

10 (3) may not offer services out-of-plan without
11 providing those services on an in-plan basis;

12 (4) may include annual out-of-pocket limits and
13 lifetime maximum benefits allowances for out-of-plan
14 services that are separate from any limits or allowances
15 applied to in-plan services;

16 (5) may not consider emergency services, authorized
17 referral services, or non-routine services obtained out of
18 the service area to be point-of-service services;

19 (6) may treat as out-of-plan services those services
20 that an enrollee obtains from a participating provider,
21 but for which the proper authorization was not given by
22 the health maintenance organization; and

23 (7) after January 1, 2003 (the effective date of
24 Public Act 92-579), must include the following disclosure
25 on its point-of-service contracts and evidences of
26 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN

1 NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO
2 PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE
3 POLICY IN NON-EMERGENCY SITUATIONS. Except in limited
4 situations governed by the federal No Surprises Act or
5 Section 356z.3a of the Illinois Insurance Code (215 ILCS
6 5/356z.3a), non-participating providers furnishing
7 non-emergency services may bill members for any amount up
8 to the billed charge after the plan has paid its portion of
9 the bill. If you elect to use a non-participating
10 provider, plan benefit payments will be determined
11 according to your policy's fee schedule, usual and
12 customary charge (which is determined by comparing charges
13 for similar services adjusted to the geographical area
14 where the services are performed), or other method as
15 defined by the policy. Participating providers have agreed
16 to ONLY bill members the cost-sharing amounts. You should
17 ~~be aware that when you elect to utilize the services of a~~
18 ~~non participating provider for a covered service in~~
19 ~~non emergency situations, benefit payments to such~~
20 ~~non-participating provider are not based upon the amount~~
21 ~~billed. The basis of your benefit payment will be~~
22 ~~determined according to your policy's fee schedule, usual~~
23 ~~and customary charge (which is determined by comparing~~
24 ~~charges for similar services adjusted to the geographical~~
25 ~~area where the services are performed), or other method as~~
26 ~~defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE~~

1 ~~COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN~~
2 ~~HAS PAID ITS REQUIRED PORTION. Non-participating providers~~
3 ~~may bill members for any amount up to the billed charge~~
4 ~~after the plan has paid its portion of the bill, except as~~
5 ~~provided in Section 356z.3a of the Illinois Insurance Code~~
6 ~~for covered services received at a participating health~~
7 ~~care facility from a non-participating provider that are:~~
8 ~~(a) ancillary services, (b) items or services furnished as~~
9 ~~a result of unforeseen, urgent medical needs that arise at~~
10 ~~the time the item or service is furnished, or (c) items or~~
11 ~~services received when the facility or the~~
12 ~~non-participating provider fails to satisfy the notice and~~
13 ~~consent criteria specified under Section 356z.3a.~~
14 ~~Participating providers have agreed to accept discounted~~
15 ~~payments for services with no additional billing to the~~
16 ~~member other than co-insurance and deductible amounts. You~~
17 ~~may obtain further information about the participating~~
18 ~~status of professional providers and information on~~
19 ~~out-of-pocket expenses by calling the toll-free ~~toll-free~~~~
20 ~~telephone number on your identification card."~~

21 (b) A health maintenance organization offering a
22 point-of-service contract is subject to all of the following
23 limitations:

24 (1) The health maintenance organization may not expend
25 in any calendar quarter more than 20% of its total
26 expenditures for all its members for out-of-plan covered

1 services.

2 (2) If the amount specified in item (1) of this
3 subsection is exceeded by 2% in a quarter, the health
4 maintenance organization must effect compliance with item
5 (1) of this subsection by the end of the following
6 quarter.

7 (3) If compliance with the amount specified in item
8 (1) of this subsection is not demonstrated in the health
9 maintenance organization's next quarterly report, the
10 health maintenance organization may not offer the
11 point-of-service contract to new groups or include the
12 point-of-service option in the renewal of an existing
13 group until compliance with the amount specified in item
14 (1) of this subsection is demonstrated or until otherwise
15 allowed by the Director.

16 (4) A health maintenance organization failing, without
17 just cause, to comply with the provisions of this
18 subsection shall be required, after notice and hearing, to
19 pay a penalty of \$250 for each day out of compliance, to be
20 recovered by the Director. Any penalty recovered shall be
21 paid into the General Revenue Fund. The Director may
22 reduce the penalty if the health maintenance organization
23 demonstrates to the Director that the imposition of the
24 penalty would constitute a financial hardship to the
25 health maintenance organization.

26 (c) A health maintenance organization that offers a

1 point-of-service product must do all of the following:

2 (1) File a quarterly financial statement detailing
3 compliance with the requirements of subsection (b).

4 (2) Track out-of-plan, point-of-service utilization
5 separately from in-plan or non-point-of-service,
6 out-of-plan emergency care, referral care, and urgent care
7 out of the service area utilization.

8 (3) Record out-of-plan utilization in a manner that
9 will permit such utilization and cost reporting as the
10 Director may, by rule, require.

11 (4) Demonstrate to the Director's satisfaction that
12 the health maintenance organization has the fiscal,
13 administrative, and marketing capacity to control its
14 point-of-service enrollment, utilization, and costs so as
15 not to jeopardize the financial security of the health
16 maintenance organization.

17 (5) Maintain, in addition to any other deposit
18 required under this Act, the deposit required by Section
19 2-6.

20 (6) Maintain cash and cash equivalents of sufficient
21 amount to fully liquidate 10 days' average claim payments,
22 subject to review by the Director.

23 (7) Maintain and file with the Director, reinsurance
24 coverage protecting against catastrophic losses on
25 out-of-network point-of-service services. Deductibles may
26 not exceed \$100,000 per covered life per year, and the

1 portion of risk retained by the health maintenance
2 organization once deductibles have been satisfied may not
3 exceed 20%. Reinsurance must be placed with licensed
4 authorized reinsurers qualified to do business in this
5 State.

6 (d) A health maintenance organization may not issue a
7 point-of-service contract until it has filed and had approved
8 by the Director a plan to comply with the provisions of this
9 Section. The compliance plan must, at a minimum, include
10 provisions demonstrating that the health maintenance
11 organization will do all of the following:

12 (1) Design the benefit levels and conditions of
13 coverage for in-plan covered services and out-of-plan
14 covered services as required by this Article.

15 (2) Provide or arrange for the provision of adequate
16 systems to:

17 (A) process and pay claims for all out-of-plan
18 covered services;

19 (B) meet the requirements for point-of-service
20 contracts set forth in this Section and any additional
21 requirements that may be set forth by the Director;
22 and

23 (C) generate accurate data and financial and
24 regulatory reports on a timely basis so that the
25 Department of Insurance can evaluate the health
26 maintenance organization's experience with the

1 point-of-service contract and monitor compliance with
2 point-of-service contract provisions.

3 (3) Comply with the requirements of subsections (b)
4 and (c).

5 (Source: P.A. 102-901, eff. 1-1-23; 103-154, eff. 6-30-23.)

6 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

7 Sec. 5-3. Insurance Code provisions.

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

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

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

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

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

11 (3) a corporation organized under the laws of another
12 state, 30% or more of the enrollees of which are residents
13 of this State, except a corporation subject to
14 substantially the same requirements in its state of
15 organization as is a "domestic company" under Article VIII
16 1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 enrollment unit.

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

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

12 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
13 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
14 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
15 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
16 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
17 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
18 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
19 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
20 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
21 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

22 (215 ILCS 125/5-3.1)

23 Sec. 5-3.1. Access to obstetrical and gynecological care
24 ~~Woman's health care provider~~. Health maintenance organizations
25 are subject to the provisions of Section 356r of the Illinois

1 Insurance Code.

2 (Source: P.A. 89-514, eff. 7-17-96.)

3 Section 40. The Limited Health Service Organization Act is
4 amended by changing Sections 4002.1 and 4003 as follows:

5 (215 ILCS 130/4002.1)

6 Sec. 4002.1. Access to obstetrical and gynecological care
7 ~~Woman's health care provider.~~ Limited health service
8 organizations are subject to the provisions of Section 356r of
9 the Illinois Insurance Code.

10 (Source: P.A. 89-514, eff. 7-17-96.)

11 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

12 Sec. 4003. Illinois Insurance Code provisions. Limited
13 health service organizations shall be subject to the
14 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
15 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,
16 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 355.2,
17 355.3, 355b, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21,
18 356z.22, 356z.25, 356z.26, 356z.29, ~~356z.30a,~~ 356z.32,
19 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54,
20 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 364.3,
21 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444,
22 and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII
23 1/2, XXV, and XXVI of the Illinois Insurance Code. Nothing in

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

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

8 (2) a corporation organized under the laws of another
9 state, 30% or more of the enrollees of which are residents
10 of this State, except a corporation subject to
11 substantially the same requirements in its state of
12 organization as is a domestic company under Article VIII
13 1/2 of the Illinois Insurance Code.

14 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
15 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.
16 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,
17 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
18 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
19 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
20 eff. 1-1-24; revised 8-29-23.)

21 Section 43. The Voluntary Health Services Plans Act is
22 amended by changing Section 10 as follows:

23 (215 ILCS 165/10) (from Ch. 32, par. 604)

24 Sec. 10. Application of Insurance Code provisions. Health

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

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

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

1 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
2 103-551, eff. 8-11-23; revised 8-29-23.)

3 Section 45. The Illinois Public Aid Code is amended by
4 changing Section 5-16.9 as follows:

5 (305 ILCS 5/5-16.9)

6 Sec. 5-16.9. Access to obstetrical and gynecological care
7 ~~Woman's health care provider~~. The medical assistance program
8 is subject to the provisions of Section 356r of the Illinois
9 Insurance Code. The Illinois Department shall adopt rules to
10 implement the requirements of Section 356r of the Illinois
11 Insurance Code in the medical assistance program including
12 managed care components.

13 On and after July 1, 2012, the Department shall reduce any
14 rate of reimbursement for services or other payments or alter
15 any methodologies authorized by this Code to reduce any rate
16 of reimbursement for services or other payments in accordance
17 with Section 5-5e.

18 (Source: P.A. 97-689, eff. 6-14-12.)

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

1 made by this Act or (ii) provisions derived from any other
2 Public Act.

3 Section 99. Effective date. This Act takes effect upon
4 becoming law, except that the changes to Sections 356r, 356s,
5 356z.3, and 367a of the Illinois Insurance Code and Section
6 4.5-1 of the Health Maintenance Organization Act take effect
7 January 1, 2025.