

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 Comprehensive Health Insurance Plan Act is
5 amended by changing Sections 7 and 8 as follows:

6 (215 ILCS 105/7) (from Ch. 73, par. 1307)

7 Sec. 7. Eligibility.

8 a. Except as provided in subsection (e) of this Section or
9 in Section 15 of this Act, any person who is either a citizen
10 of the United States or an alien lawfully admitted for
11 permanent residence and who has been for a period of at least
12 180 days and continues to be a resident of this State shall be
13 eligible for Plan coverage under this Section if evidence is
14 provided of:

15 (1) A notice of rejection or refusal to issue
16 substantially similar individual health insurance coverage
17 for health reasons by a health insurance issuer; or

18 (2) A refusal by a health insurance issuer to issue
19 individual health insurance coverage except at a rate
20 exceeding the applicable Plan rate for which the person is
21 responsible.

22 A rejection or refusal by a group health plan or health
23 insurance issuer offering only stop-loss or excess of loss
24 insurance or contracts, agreements, or other arrangements for
25 reinsurance coverage with respect to the applicant shall not be
26 sufficient evidence under this subsection.

27 b. The board shall promulgate a list of medical or health
28 conditions for which a person who is either a citizen of the
29 United States or an alien lawfully admitted for permanent
30 residence and a resident of this State would be eligible for
31 Plan coverage without applying for health insurance coverage
32 pursuant to subsection a. of this Section. Persons who can

1 demonstrate the existence or history of any medical or health
2 conditions on the list promulgated by the board shall not be
3 required to provide the evidence specified in subsection a. of
4 this Section. The list shall be effective on the first day of
5 the operation of the Plan and may be amended from time to time
6 as appropriate.

7 c. Family members of the same household who each are
8 covered persons are eligible for optional family coverage under
9 the Plan.

10 d. For persons qualifying for coverage in accordance with
11 Section 7 of this Act, the board shall, if it determines that
12 such appropriations as are made pursuant to Section 12 of this
13 Act are insufficient to allow the board to accept all of the
14 eligible persons which it projects will apply for enrollment
15 under the Plan, limit or close enrollment to ensure that the
16 Plan is not over-subscribed and that it has sufficient
17 resources to meet its obligations to existing enrollees. The
18 board shall not limit or close enrollment for federally
19 eligible individuals.

20 e. A person shall not be eligible for coverage under the
21 Plan if:

22 (1) He or she has or obtains other coverage under a
23 group health plan or health insurance coverage
24 substantially similar to or better than a Plan policy as an
25 insured or covered dependent or would be eligible to have
26 that coverage if he or she elected to obtain it. Persons
27 otherwise eligible for Plan coverage may, however, solely
28 for the purpose of having coverage for a pre-existing
29 condition, maintain other coverage only while satisfying
30 any pre-existing condition waiting period under a Plan
31 policy or a subsequent replacement policy of a Plan policy.

32 (1.1) His or her prior coverage under a group health
33 plan or health insurance coverage, provided or arranged by
34 an employer of more than 10 employees was discontinued for
35 any reason without the entire group or plan being
36 discontinued and not replaced, provided he or she remains

1 an employee, or dependent thereof, of the same employer.

2 (2) He or she is a recipient of or is approved to
3 receive medical assistance, except that a person may
4 continue to receive medical assistance through the medical
5 assistance no grant program, but only while satisfying the
6 requirements for a preexisting condition under Section 8,
7 subsection f. of this Act. Payment of premiums pursuant to
8 this Act shall be allocable to the person's spenddown for
9 purposes of the medical assistance no grant program, but
10 that person shall not be eligible for any Plan benefits
11 while that person remains eligible for medical assistance.
12 If the person continues to receive or be approved to
13 receive medical assistance through the medical assistance
14 no grant program at or after the time that requirements for
15 a preexisting condition are satisfied, the person shall not
16 be eligible for coverage under the Plan. In that
17 circumstance, coverage under the plan shall terminate as of
18 the expiration of the preexisting condition limitation
19 period. Under all other circumstances, coverage under the
20 Plan shall automatically terminate as of the effective date
21 of any medical assistance.

22 (3) Except as provided in Section 15, the person has
23 previously participated in the Plan and voluntarily
24 terminated Plan coverage, unless 12 months have elapsed
25 since the person's latest voluntary termination of
26 coverage.

27 (4) The person fails to pay the required premium under
28 the covered person's terms of enrollment and
29 participation, in which event the liability of the Plan
30 shall be limited to benefits incurred under the Plan for
31 the time period for which premiums had been paid and the
32 covered person remained eligible for Plan coverage.

33 (5) The Plan has paid a total of \$1,500,000 ~~\$1,000,000~~
34 in benefits on behalf of the covered person.

35 (6) The person is a resident of a public institution.

36 (7) The person's premium is paid for or reimbursed

1 under any government sponsored program or by any government
2 agency or health care provider, except as an otherwise
3 qualifying full-time employee, or dependent of such
4 employee, of a government agency or health care provider
5 or, except when a person's premium is paid by the U.S.
6 Treasury Department pursuant to the federal Trade Act of
7 2002.

8 (8) The person has or later receives other benefits or
9 funds from any settlement, judgement, or award resulting
10 from any accident or injury, regardless of the date of the
11 accident or injury, or any other circumstances creating a
12 legal liability for damages due that person by a third
13 party, whether the settlement, judgment, or award is in the
14 form of a contract, agreement, or trust on behalf of a
15 minor or otherwise and whether the settlement, judgment, or
16 award is payable to the person, his or her dependent,
17 estate, personal representative, or guardian in a lump sum
18 or over time, so long as there continues to be benefits or
19 assets remaining from those sources in an amount in excess
20 of \$300,000.

21 (9) Within the 5 years prior to the date a person's
22 Plan application is received by the Board, the person's
23 coverage under any health care benefit program as defined
24 in 18 U.S.C. 24, including any public or private plan or
25 contract under which any medical benefit, item, or service
26 is provided, was terminated as a result of any act or
27 practice that constitutes fraud under State or federal law
28 or as a result of an intentional misrepresentation of
29 material fact; or if that person knowingly and willfully
30 obtained or attempted to obtain, or fraudulently aided or
31 attempted to aid any other person in obtaining, any
32 coverage or benefits under the Plan to which that person
33 was not entitled.

34 f. The board or the administrator shall require
35 verification of residency and may require any additional
36 information or documentation, or statements under oath, when

1 necessary to determine residency upon initial application and
2 for the entire term of the policy.

3 g. Coverage shall cease (i) on the date a person is no
4 longer a resident of Illinois, (ii) on the date a person
5 requests coverage to end, (iii) upon the death of the covered
6 person, (iv) on the date State law requires cancellation of the
7 policy, or (v) at the Plan's option, 30 days after the Plan
8 makes any inquiry concerning a person's eligibility or place of
9 residence to which the person does not reply.

10 h. Except under the conditions set forth in subsection g of
11 this Section, the coverage of any person who ceases to meet the
12 eligibility requirements of this Section shall be terminated at
13 the end of the current policy period for which the necessary
14 premiums have been paid.

15 (Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 94-17,
16 eff. 1-1-06.)

17 (215 ILCS 105/8) (from Ch. 73, par. 1308)

18 Sec. 8. Minimum benefits.

19 a. Availability. The Plan shall offer in an annually
20 renewable policy major medical expense coverage to every
21 eligible person who is not eligible for Medicare. Major medical
22 expense coverage offered by the Plan shall pay an eligible
23 person's covered expenses, subject to limit on the deductible
24 and coinsurance payments authorized under paragraph (4) of
25 subsection d of this Section, up to a lifetime benefit limit of
26 \$1,500,000 ~~\$1,000,000~~ per covered individual. The maximum
27 limit under this subsection shall not be altered by the Board,
28 and no actuarial equivalent benefit may be substituted by the
29 Board. Any person who otherwise would qualify for coverage
30 under the Plan, but is excluded because he or she is eligible
31 for Medicare, shall be eligible for any separate Medicare
32 supplement policy or policies which the Board may offer.

33 b. Outline of benefits. Covered expenses shall be limited
34 to the usual and customary charge, including negotiated fees,
35 in the locality for the following services and articles when

1 prescribed by a physician and determined by the Plan to be
2 medically necessary for the following areas of services,
3 subject to such separate deductibles, co-payments, exclusions,
4 and other limitations on benefits as the Board shall establish
5 and approve, and the other provisions of this Section:

6 (1) Hospital services, except that any services
7 provided by a hospital that is located more than 75 miles
8 outside the State of Illinois shall be covered only for a
9 maximum of 45 days in any calendar year. With respect to
10 covered expenses incurred during any calendar year ending
11 on or after December 31, 1999, inpatient hospitalization of
12 an eligible person for the treatment of mental illness at a
13 hospital located within the State of Illinois shall be
14 subject to the same terms and conditions as for any other
15 illness.

16 (2) Professional services for the diagnosis or
17 treatment of injuries, illnesses or conditions, other than
18 dental and mental and nervous disorders as described in
19 paragraph (17), which are rendered by a physician, or by
20 other licensed professionals at the physician's direction.
21 This includes reconstruction of the breast on which a
22 mastectomy was performed; surgery and reconstruction of
23 the other breast to produce a symmetrical appearance; and
24 prostheses and treatment of physical complications at all
25 stages of the mastectomy, including lymphedemas.

26 (2.5) Professional services provided by a physician to
27 children under the age of 16 years for physical
28 examinations and age appropriate immunizations ordered by
29 a physician licensed to practice medicine in all its
30 branches.

31 (3) (Blank).

32 (4) Outpatient prescription drugs that by law require a
33 prescription written by a physician licensed to practice
34 medicine in all its branches subject to such separate
35 deductible, copayment, and other limitations or
36 restrictions as the Board shall approve, including the use

1 of a prescription drug card or any other program, or both.

2 (5) Skilled nursing services of a licensed skilled
3 nursing facility for not more than 120 days during a policy
4 year.

5 (6) Services of a home health agency in accord with a
6 home health care plan, up to a maximum of 270 visits per
7 year.

8 (7) Services of a licensed hospice for not more than
9 180 days during a policy year.

10 (8) Use of radium or other radioactive materials.

11 (9) Oxygen.

12 (10) Anesthetics.

13 (11) Orthoses and prostheses other than dental.

14 (12) Rental or purchase in accordance with Board
15 policies or procedures of durable medical equipment, other
16 than eyeglasses or hearing aids, for which there is no
17 personal use in the absence of the condition for which it
18 is prescribed.

19 (13) Diagnostic x-rays and laboratory tests.

20 (14) Oral surgery (i) for excision of partially or
21 completely unerupted impacted teeth when not performed in
22 connection with the routine extraction or repair of teeth;
23 (ii) for excision of tumors or cysts of the jaws, cheeks,
24 lips, tongue, and roof and floor of the mouth; (iii)
25 required for correction of cleft lip and palate and other
26 craniofacial and maxillofacial birth defects; or (iv) for
27 treatment of injuries to natural teeth or a fractured jaw
28 due to an accident.

29 (15) Physical, speech, and functional occupational
30 therapy as medically necessary and provided by appropriate
31 licensed professionals.

32 (16) Emergency and other medically necessary
33 transportation provided by a licensed ambulance service to
34 the nearest health care facility qualified to treat a
35 covered illness, injury, or condition, subject to the
36 provisions of the Emergency Medical Systems (EMS) Act.

1 (17) Outpatient services for diagnosis and treatment
2 of mental and nervous disorders provided that a covered
3 person shall be required to make a copayment not to exceed
4 50% and that the Plan's payment shall not exceed such
5 amounts as are established by the Board.

6 (18) Human organ or tissue transplants specified by the
7 Board that are performed at a hospital designated by the
8 Board as a participating transplant center for that
9 specific organ or tissue transplant.

10 (19) Naprapathic services, as appropriate, provided by
11 a licensed naprapathic practitioner.

12 c. Exclusions. Covered expenses of the Plan shall not
13 include the following:

14 (1) Any charge for treatment for cosmetic purposes
15 other than for reconstructive surgery when the service is
16 incidental to or follows surgery resulting from injury,
17 sickness or other diseases of the involved part or surgery
18 for the repair or treatment of a congenital bodily defect
19 to restore normal bodily functions.

20 (2) Any charge for care that is primarily for rest,
21 custodial, educational, or domiciliary purposes.

22 (3) Any charge for services in a private room to the
23 extent it is in excess of the institution's charge for its
24 most common semiprivate room, unless a private room is
25 prescribed as medically necessary by a physician.

26 (4) That part of any charge for room and board or for
27 services rendered or articles prescribed by a physician,
28 dentist, or other health care personnel that exceeds the
29 reasonable and customary charge in the locality or for any
30 services or supplies not medically necessary for the
31 diagnosed injury or illness.

32 (5) Any charge for services or articles the provision
33 of which is not within the scope of licensure of the
34 institution or individual providing the services or
35 articles.

36 (6) Any expense incurred prior to the effective date of

1 coverage by the Plan for the person on whose behalf the
2 expense is incurred.

3 (7) Dental care, dental surgery, dental treatment, any
4 other dental procedure involving the teeth or
5 periodontium, or any dental appliances, including crowns,
6 bridges, implants, or partial or complete dentures, except
7 as specifically provided in paragraph (14) of subsection b
8 of this Section.

9 (8) Eyeglasses, contact lenses, hearing aids or their
10 fitting.

11 (9) Illness or injury due to acts of war.

12 (10) Services of blood donors and any fee for failure
13 to replace the first 3 pints of blood provided to a covered
14 person each policy year.

15 (11) Personal supplies or services provided by a
16 hospital or nursing home, or any other nonmedical or
17 nonprescribed supply or service.

18 (12) Routine maternity charges for a pregnancy, except
19 where added as optional coverage with payment of an
20 additional premium for pregnancy resulting from conception
21 occurring after the effective date of the optional
22 coverage.

23 (13) (Blank).

24 (14) Any expense or charge for services, drugs, or
25 supplies that are: (i) not provided in accord with
26 generally accepted standards of current medical practice;
27 (ii) for procedures, treatments, equipment, transplants,
28 or implants, any of which are investigational,
29 experimental, or for research purposes; (iii)
30 investigative and not proven safe and effective; or (iv)
31 for, or resulting from, a gender transformation operation.

32 (15) Any expense or charge for routine physical
33 examinations or tests except as provided in item (2.5) of
34 subsection b of this Section.

35 (16) Any expense for which a charge is not made in the
36 absence of insurance or for which there is no legal

1 obligation on the part of the patient to pay.

2 (17) Any expense incurred for benefits provided under
3 the laws of the United States and this State, including
4 Medicare, Medicaid, and other medical assistance, maternal
5 and child health services and any other program that is
6 administered or funded by the Department of Human Services,
7 Department of Healthcare and Family Services ~~Public Aid~~, or
8 Department of Public Health, military service-connected
9 disability payments, medical services provided for members
10 of the armed forces and their dependents or employees of
11 the armed forces of the United States, and medical services
12 financed on behalf of all citizens by the United States.

13 (18) Any expense or charge for in vitro fertilization,
14 artificial insemination, or any other artificial means
15 used to cause pregnancy.

16 (19) Any expense or charge for oral contraceptives used
17 for birth control or any other temporary birth control
18 measures.

19 (20) Any expense or charge for sterilization or
20 sterilization reversals.

21 (21) Any expense or charge for weight loss programs,
22 exercise equipment, or treatment of obesity, except when
23 certified by a physician as morbid obesity (at least 2
24 times normal body weight).

25 (22) Any expense or charge for acupuncture treatment
26 unless used as an anesthetic agent for a covered surgery.

27 (23) Any expense or charge for or related to organ or
28 tissue transplants other than those performed at a hospital
29 with a Board approved organ transplant program that has
30 been designated by the Board as a preferred or exclusive
31 provider organization for that specific organ or tissue
32 transplant.

33 (24) Any expense or charge for procedures, treatments,
34 equipment, or services that are provided in special
35 settings for research purposes or in a controlled
36 environment, are being studied for safety, efficiency, and

1 effectiveness, and are awaiting endorsement by the
2 appropriate national medical speciality college for
3 general use within the medical community.

4 d. Deductibles and coinsurance.

5 The Plan coverage defined in Section 6 shall provide for a
6 choice of deductibles per individual as authorized by the
7 Board. If 2 individual members of the same family household,
8 who are both covered persons under the Plan, satisfy the same
9 applicable deductibles, no other member of that family who is
10 also a covered person under the Plan shall be required to meet
11 any deductibles for the balance of that calendar year. The
12 deductibles must be applied first to the authorized amount of
13 covered expenses incurred by the covered person. A mandatory
14 coinsurance requirement shall be imposed at the rate authorized
15 by the Board in excess of the mandatory deductible, the
16 coinsurance in the aggregate not to exceed such amounts as are
17 authorized by the Board per annum. At its discretion the Board
18 may, however, offer catastrophic coverages or other policies
19 that provide for larger deductibles with or without coinsurance
20 requirements. The deductibles and coinsurance factors may be
21 adjusted annually according to the Medical Component of the
22 Consumer Price Index.

23 e. Scope of coverage.

24 (1) In approving any of the benefit plans to be offered
25 by the Plan, the Board shall establish such benefit levels,
26 deductibles, coinsurance factors, exclusions, and
27 limitations as it may deem appropriate and that it believes
28 to be generally reflective of and commensurate with health
29 insurance coverage that is provided in the individual
30 market in this State.

31 (2) The benefit plans approved by the Board may also
32 provide for and employ various cost containment measures
33 and other requirements including, but not limited to,
34 preadmission certification, prior approval, second
35 surgical opinions, concurrent utilization review programs,
36 individual case management, preferred provider

1 organizations, health maintenance organizations, and other
2 cost effective arrangements for paying for covered
3 expenses.

4 f. Preexisting conditions.

5 (1) Except for federally eligible individuals
6 qualifying for Plan coverage under Section 15 of this Act
7 or eligible persons who qualify for the waiver authorized
8 in paragraph (3) of this subsection, plan coverage shall
9 exclude charges or expenses incurred during the first 6
10 months following the effective date of coverage as to any
11 condition for which medical advice, care or treatment was
12 recommended or received during the 6 month period
13 immediately preceding the effective date of coverage.

14 (2) (Blank).

15 (3) Waiver: The preexisting condition exclusions as
16 set forth in paragraph (1) of this subsection shall be
17 waived to the extent to which the eligible person (a) has
18 satisfied similar exclusions under any prior individual
19 health insurance policy that was involuntarily terminated
20 because of the insolvency of the issuer of the policy and
21 (b) has applied for Plan coverage within 90 days following
22 the involuntary termination of that individual health
23 insurance coverage.

24 g. Other sources primary; nonduplication of benefits.

25 (1) The Plan shall be the last payor of benefits
26 whenever any other benefit or source of third party payment
27 is available. Subject to the provisions of subsection e of
28 Section 7, benefits otherwise payable under Plan coverage
29 shall be reduced by all amounts paid or payable by Medicare
30 or any other government program or through any health
31 insurance coverage or group health plan, whether by
32 insurance, reimbursement, or otherwise, or through any
33 third party liability, settlement, judgment, or award,
34 regardless of the date of the settlement, judgment, or
35 award, whether the settlement, judgment, or award is in the
36 form of a contract, agreement, or trust on behalf of a

1 minor or otherwise and whether the settlement, judgment, or
2 award is payable to the covered person, his or her
3 dependent, estate, personal representative, or guardian in
4 a lump sum or over time, and by all hospital or medical
5 expense benefits paid or payable under any worker's
6 compensation coverage, automobile medical payment, or
7 liability insurance, whether provided on the basis of fault
8 or nonfault, and by any hospital or medical benefits paid
9 or payable under or provided pursuant to any State or
10 federal law or program.

11 (2) The Plan shall have a cause of action against any
12 covered person or any other person or entity for the
13 recovery of any amount paid to the extent the amount was
14 for treatment, services, or supplies not covered in this
15 Section or in excess of benefits as set forth in this
16 Section.

17 (3) Whenever benefits are due from the Plan because of
18 sickness or an injury to a covered person resulting from a
19 third party's wrongful act or negligence and the covered
20 person has recovered or may recover damages from a third
21 party or its insurer, the Plan shall have the right to
22 reduce benefits or to refuse to pay benefits that otherwise
23 may be payable by the amount of damages that the covered
24 person has recovered or may recover regardless of the date
25 of the sickness or injury or the date of any settlement,
26 judgment, or award resulting from that sickness or injury.

27 During the pendency of any action or claim that is
28 brought by or on behalf of a covered person against a third
29 party or its insurer, any benefits that would otherwise be
30 payable except for the provisions of this paragraph (3)
31 shall be paid if payment by or for the third party has not
32 yet been made and the covered person or, if incapable, that
33 person's legal representative agrees in writing to pay back
34 promptly the benefits paid as a result of the sickness or
35 injury to the extent of any future payments made by or for
36 the third party for the sickness or injury. This agreement

1 is to apply whether or not liability for the payments is
2 established or admitted by the third party or whether those
3 payments are itemized.

4 Any amounts due the plan to repay benefits may be
5 deducted from other benefits payable by the Plan after
6 payments by or for the third party are made.

7 (4) Benefits due from the Plan may be reduced or
8 refused as an offset against any amount otherwise
9 recoverable under this Section.

10 h. Right of subrogation; recoveries.

11 (1) Whenever the Plan has paid benefits because of
12 sickness or an injury to any covered person resulting from
13 a third party's wrongful act or negligence, or for which an
14 insurer is liable in accordance with the provisions of any
15 policy of insurance, and the covered person has recovered
16 or may recover damages from a third party that is liable
17 for the damages, the Plan shall have the right to recover
18 the benefits it paid from any amounts that the covered
19 person has received or may receive regardless of the date
20 of the sickness or injury or the date of any settlement,
21 judgment, or award resulting from that sickness or injury.
22 The Plan shall be subrogated to any right of recovery the
23 covered person may have under the terms of any private or
24 public health care coverage or liability coverage,
25 including coverage under the Workers' Compensation Act or
26 the Workers' Occupational Diseases Act, without the
27 necessity of assignment of claim or other authorization to
28 secure the right of recovery. To enforce its subrogation
29 right, the Plan may (i) intervene or join in an action or
30 proceeding brought by the covered person or his personal
31 representative, including his guardian, conservator,
32 estate, dependents, or survivors, against any third party
33 or the third party's insurer that may be liable or (ii)
34 institute and prosecute legal proceedings against any
35 third party or the third party's insurer that may be liable
36 for the sickness or injury in an appropriate court either

1 in the name of the Plan or in the name of the covered
2 person or his personal representative, including his
3 guardian, conservator, estate, dependents, or survivors.

4 (2) If any action or claim is brought by or on behalf
5 of a covered person against a third party or the third
6 party's insurer, the covered person or his personal
7 representative, including his guardian, conservator,
8 estate, dependents, or survivors, shall notify the Plan by
9 personal service or registered mail of the action or claim
10 and of the name of the court in which the action or claim
11 is brought, filing proof thereof in the action or claim.
12 The Plan may, at any time thereafter, join in the action or
13 claim upon its motion so that all orders of court after
14 hearing and judgment shall be made for its protection. No
15 release or settlement of a claim for damages and no
16 satisfaction of judgment in the action shall be valid
17 without the written consent of the Plan to the extent of
18 its interest in the settlement or judgment and of the
19 covered person or his personal representative.

20 (3) In the event that the covered person or his
21 personal representative fails to institute a proceeding
22 against any appropriate third party before the fifth month
23 before the action would be barred, the Plan may, in its own
24 name or in the name of the covered person or personal
25 representative, commence a proceeding against any
26 appropriate third party for the recovery of damages on
27 account of any sickness, injury, or death to the covered
28 person. The covered person shall cooperate in doing what is
29 reasonably necessary to assist the Plan in any recovery and
30 shall not take any action that would prejudice the Plan's
31 right to recovery. The Plan shall pay to the covered person
32 or his personal representative all sums collected from any
33 third party by judgment or otherwise in excess of amounts
34 paid in benefits under the Plan and amounts paid or to be
35 paid as costs, attorneys fees, and reasonable expenses
36 incurred by the Plan in making the collection or enforcing

1 the judgment.

2 (4) In the event that a covered person or his personal
3 representative, including his guardian, conservator,
4 estate, dependents, or survivors, recovers damages from a
5 third party for sickness or injury caused to the covered
6 person, the covered person or the personal representative
7 shall pay to the Plan from the damages recovered the amount
8 of benefits paid or to be paid on behalf of the covered
9 person.

10 (5) When the action or claim is brought by the covered
11 person alone and the covered person incurs a personal
12 liability to pay attorney's fees and costs of litigation,
13 the Plan's claim for reimbursement of the benefits provided
14 to the covered person shall be the full amount of benefits
15 paid to or on behalf of the covered person under this Act
16 less a pro rata share that represents the Plan's reasonable
17 share of attorney's fees paid by the covered person and
18 that portion of the cost of litigation expenses determined
19 by multiplying by the ratio of the full amount of the
20 expenditures to the full amount of the judgement, award, or
21 settlement.

22 (6) In the event of judgment or award in a suit or
23 claim against a third party or insurer, the court shall
24 first order paid from any judgement or award the reasonable
25 litigation expenses incurred in preparation and
26 prosecution of the action or claim, together with
27 reasonable attorney's fees. After payment of those
28 expenses and attorney's fees, the court shall apply out of
29 the balance of the judgment or award an amount sufficient
30 to reimburse the Plan the full amount of benefits paid on
31 behalf of the covered person under this Act, provided the
32 court may reduce and apportion the Plan's portion of the
33 judgement proportionate to the recovery of the covered
34 person. The burden of producing evidence sufficient to
35 support the exercise by the court of its discretion to
36 reduce the amount of a proven charge sought to be enforced

1 against the recovery shall rest with the party seeking the
2 reduction. The court may consider the nature and extent of
3 the injury, economic and non-economic loss, settlement
4 offers, comparative negligence as it applies to the case at
5 hand, hospital costs, physician costs, and all other
6 appropriate costs. The Plan shall pay its pro rata share of
7 the attorney fees based on the Plan's recovery as it
8 compares to the total judgment. Any reimbursement rights of
9 the Plan shall take priority over all other liens and
10 charges existing under the laws of this State with the
11 exception of any attorney liens filed under the Attorneys
12 Lien Act.

13 (7) The Plan may compromise or settle and release any
14 claim for benefits provided under this Act or waive any
15 claims for benefits, in whole or in part, for the
16 convenience of the Plan or if the Plan determines that
17 collection would result in undue hardship upon the covered
18 person.

19 (Source: P.A. 91-639, eff. 8-20-99; 91-735, eff. 6-2-00; 92-2,
20 eff. 5-1-01; 92-630, eff. 7-11-02; revised 12-15-05.)

21 Section 99. Effective date. This Act takes effect upon
22 becoming law.