

AN ACT concerning government.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Sections 2, 6.1, 6.2, 7, 8, 10, 13, and 13.1 as follows:

(5 ILCS 375/2) (from Ch. 127, par. 522)

Sec. 2. Purpose. The purpose of this Act is to provide a program of group life insurance, a program of health benefits and other employee benefits for persons in the service of the State of Illinois, ~~employees of local governments, employees of rehabilitation facilities, employees of domestic violence shelters and services, and employees of child advocacy centers,~~ and certain of their dependents. It is also the purpose of this Act to provide a program of health benefits (i) for certain benefit recipients of the Teachers' Retirement System of the State of Illinois and their dependent beneficiaries, and (ii) for certain eligible retired community college employees and their dependent beneficiaries, and (iii) for employees of local governments, employees of rehabilitation facilities, employees of domestic violence shelters and services, and employees of child advocacy centers, and certain of their dependents.

(Source: P.A. 94-860, eff. 6-16-06.)

(5 ILCS 375/6.1) (from Ch. 127, par. 526.1)

Sec. 6.1. The program of health benefits may offer as an alternative, available on an optional basis, coverage through health maintenance organizations or other managed care programs. That part of the premium for such coverage which is in excess of the amount which would otherwise be paid by the State for the program of health benefits shall be paid by the member who elects such alternative coverage and shall be collected as provided for premiums for other optional coverages.

(Source: P.A. 100-538, eff. 1-1-18.)

(5 ILCS 375/6.2) (from Ch. 127, par. 526.2)

Sec. 6.2. When the Director, with the advice and consent of the Commission, determines that it would be in the best interests of the State and its employees, any ~~the~~ program of health benefits under this Act may be administered with the State as a self-insurer in whole or in part. The State assumes the risks of any such ~~the~~ program. The State may provide the administrative services in connection with any ~~the~~ self-insurance health plan or purchase administrative services from an administrative service organization. A plan of self-insurance may combine forms of re-insurance or stop-loss insurance which limits the amount of State liability.

The program of health benefits shall provide a continuation and conversion privilege for persons whose State employment is terminated and a continuation privilege for members' spouses and dependent children who are covered under the provisions of the program, consistent with the requirements of federal law and Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code.

(Source: P.A. 93-477, eff. 1-1-04.)

(5 ILCS 375/7) (from Ch. 127, par. 527)

Sec. 7. Group life insurance program.

(a) The basic noncontributory group life insurance program shall provide coverage as follows:

(1) employees shall be insured in an amount equal to the basic annual salary rate, exclusive of overtime, bonus, or other cumulative additional income factors, raised to the next round hundred dollar amount if it is not already a round hundred dollar amount;

(2) annuitants shall be insured in the same manner as described for active employees, based on the salary in force immediately before retirement, with coverage becoming effective on the effective date of retirement benefits or the first day of the month of application, whichever occurs later, except that at age 60 the amount of coverage for the annuitant shall be reduced to \$5,000;

(3) survivors whose coverage became effective prior to

September 22, 1979 shall be insured for \$2,000;

(4) retired employees shall not be eligible under the group life insurance program contracted to begin or continue after June 30, 1973.

(a-5) There shall also be available on an optional basis to employees, annuitants whose retirement benefits begin within one year of their receipt of final compensation, and survivors whose coverage became effective prior to September 22, 1979, a contributory program of:

(1) supplemental life insurance in an amount not exceeding 8 times the basic life benefits for active employees and annuitants under age 60 and not exceeding 4 times the basic life benefits for annuitants age 60 and over, as described above, except that (a) amounts selected by employees and annuitants must be in full multiples of the basic amount, and (b) premiums may be adjusted by age bracket established in rules supplementing this Act; beginning July 1, 1981, survivors whose coverage becomes effective on or after September 22, 1979, shall have the option of participating in the contributory program of life insurance in an amount of \$5,000 coverage;

(2) accidental death and dismemberment, with the employee and annuitant having the option of electing an amount equal to the basic noncontributory life benefits only, or an amount equaling the combined total of basic plus optional life benefits not exceeding 5 times basic

life benefits, or \$3,000,000, whichever is less;

(3) dependent life insurance in an amount of \$10,000 coverage on the spouse; however, coverage reduces to \$5,000 when the eligible spouse annuitant turns 60; and

(4) dependent life insurance in an amount of \$10,000 coverage on each dependent other than the spouse.

(b) A member, not otherwise covered by this Act, who has retired as a participating member under Article 2 of the Illinois Pension Code, but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, shall pay the premiums for coverage under the group life insurance program under this Act. The Director shall promulgate rules and regulations to determine the premiums to be paid by a member under this subsection (b).

(Source: P.A. 94-95, eff. 7-1-05.)

(5 ILCS 375/8) (from Ch. 127, par. 528)

Sec. 8. Eligibility.

(a) Each employee eligible under the provisions of this Act and any rules and regulations promulgated and adopted hereunder by the Director shall become immediately eligible and covered for all benefits available under the programs. Employees electing coverage for eligible dependents shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director, including the completion

and submission of all documentation and forms required by the Director.

(1) Every member originally eligible to elect dependent coverage, but not electing it during the original eligibility period, may subsequently obtain dependent coverage only in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

(2) Members described above being transferred from previous coverage towards which the State has been contributing shall be transferred regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled.

(3) Eligible and covered members that are eligible for coverage as dependents except for the fact of being members shall be transferred to, and covered under, dependent status regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled upon cessation of member status and the election of dependent coverage by a member eligible to elect that coverage.

(b) New employees shall be immediately insured for the basic group life insurance and covered by the program of

health benefits on the first day of active State service. Optional life insurance coverage one to 4 times the basic amount, if elected during the relevant eligibility period, will become effective on the date of employment. Optional life insurance coverage exceeding 4 times the basic amount and all life insurance amounts applied for after the eligibility period will be effective, subject to satisfactory evidence of insurability when applicable, or other necessary qualifications, pursuant to the requirements of the applicable benefit program, unless there is a change in status that would confer new eligibility for change of enrollment under rules established supplementing this Act, in which event application must be made within the new eligibility period.

(c) As to the group health benefits program contracted to begin or continue after June 30, 1973, each annuitant, survivor, and retired employee shall become immediately eligible for all benefits available under that program. Each annuitant, survivor, and retired employee shall have coverage effective immediately, provided that the election is properly filed in accordance with the required filing dates and procedures specified by the Director, including the completion and submission of all documentation and forms required by the Director. Annuitants, survivors, and retired employees may elect coverage for eligible dependents and shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and

procedures specified by the Director, except that, for a survivor, the dependent sought to be added on or after the effective date of this amendatory Act of the 97th General Assembly must have been eligible for coverage as a dependent under the deceased member upon whom the survivor's annuity is based in order to be eligible for coverage under the survivor.

Except as otherwise provided in this Act, where husband and wife are both eligible members, each shall be enrolled as a member and coverage on their eligible dependent children, if any, may be under the enrollment and election of either.

Regardless of other provisions herein regarding late enrollment or other qualifications, as appropriate, the Director may periodically authorize open enrollment periods for each of the benefit programs at which time each member may elect enrollment or change of enrollment without regard to age, sex, health, or other qualification under the conditions as may be prescribed in rules and regulations supplementing this Act. Special open enrollment periods may be declared by the Director for certain members only when special circumstances occur that affect only those members.

(d) Eligible ~~Beginning with fiscal year 2003 and for all subsequent years, eligible~~ members may elect not to participate in the program of health benefits as defined in this Act. The election must be made during the annual benefit choice period or upon showing a qualifying change in status as defined in the U.S. Internal Revenue Code, subject to the

conditions in this subsection.

(1) (Blank). ~~Members must furnish proof of health benefit coverage, either comprehensive major medical coverage or comprehensive managed care plan, from a source other than the Department of Central Management Services in order to elect not to participate in the program.~~

(2) Members may re-enroll in the Department of Central Management Services program of health benefits upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions, ~~provided that there was not a break in coverage of more than 63 days.~~

(3) Members may also re-enroll in the program of health benefits during any annual benefit choice period, without evidence of insurability.

(4) Members who elect not to participate in the program of health benefits shall be furnished a written explanation of the requirements and limitations for the election not to participate in the program and for re-enrolling in the program. The explanation shall also be included in the annual benefit choice options booklets furnished to members.

(d-5) Beginning July 1, 2005, the Director may establish a program of financial incentives to encourage annuitants receiving a retirement annuity, but who are not eligible for

benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in accordance with the requirements set forth under subsection (d). The financial incentives provided to these annuitants under the program may not exceed \$150 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(d-6) Beginning July 1, 2013, the Director may establish a program of financial incentives to encourage annuitants with 20 or more years of creditable service but who are not eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in accordance with the requirements set forth under subsection (d). The program established under this subsection (d-6) may include a prorated incentive for annuitants with fewer than 20 years of creditable service, as determined by the Director. The financial incentives provided to these annuitants under this program may not exceed \$500 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(e) Notwithstanding any other provision of this Act or the rules adopted under this Act, if a person participating in the program of health benefits as the dependent spouse of an eligible member becomes an annuitant, the person may elect, at the time of becoming an annuitant or during any subsequent annual benefit choice period, to continue participation as a dependent rather than as an eligible member for as long as the person continues to be an eligible dependent. In order to be eligible to make such an election, the person must have been enrolled as a dependent under the program of health benefits for no less than one year prior to becoming an annuitant.

An eligible member who has elected to participate as a dependent may re-enroll in the program of health benefits as an eligible member (i) during any subsequent annual benefit choice period or (ii) upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions.

A person who elects to participate in the program of health benefits as a dependent rather than as an eligible member shall be furnished a written explanation of the consequences of electing to participate as a dependent and the conditions and procedures for re-enrolling as an eligible member. The explanation shall also be included in the annual benefit choice options booklet furnished to members.

(Source: P.A. 97-668, eff. 1-13-12; 98-19, eff. 6-10-13.)

(5 ILCS 375/10) (from Ch. 127, par. 530)

Sec. 10. Contributions by the State and members.

(a) The State shall pay the cost of basic non-contributory group life insurance and, subject to member paid contributions set by the Department or required by this Section and except as provided in this Section, the basic program of group health benefits on each eligible member, except a member, not otherwise covered by this Act, who has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, and part of each eligible member's and retired member's premiums for health insurance coverage for enrolled dependents as provided by Section 9. The State shall pay the cost of the basic program of group health benefits only after benefits are reduced by the amount of benefits covered by Medicare for all members and dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, except that such reduction in benefits shall apply only to those members and dependents who (1) first become eligible for such Medicare coverage on or after July 1, 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the program on or after July 1, 1992; or (3) remain eligible for, but no longer receive

Medicare coverage which they had been receiving on or after July 1, 1992. The Department may determine the aggregate level of the State's contribution on the basis of actual cost of medical services adjusted for age, sex or geographic or other demographic characteristics which affect the costs of such programs.

The cost of participation in the basic program of group health benefits for the dependent or survivor of a living or deceased retired employee who was formerly employed by the University of Illinois in the Cooperative Extension Service and would be an annuitant but for the fact that he or she was made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code shall not be greater than the cost of participation that would otherwise apply to that dependent or survivor if he or she were the dependent or survivor of an annuitant under the State Universities Retirement System.

(a-1) (Blank).

(a-2) (Blank).

(a-3) (Blank).

(a-4) (Blank).

(a-5) (Blank).

(a-6) (Blank).

(a-7) (Blank).

(a-8) Any annuitant, survivor, or retired employee may

waive or terminate coverage in the program of group health benefits. Any such annuitant, survivor, or retired employee who has waived or terminated coverage may enroll or re-enroll in the program of group health benefits only during the annual benefit choice period, as determined by the Director; except that in the event of termination of coverage due to nonpayment of premiums, the annuitant, survivor, or retired employee may not re-enroll in the program.

(a-8.5) Beginning on the effective date of this amendatory Act of the 97th General Assembly, the Director of Central Management Services shall, on an annual basis, determine the amount that the State shall contribute toward the basic program of group health benefits on behalf of annuitants (including individuals who (i) participated in the General Assembly Retirement System, the State Employees' Retirement System of Illinois, the State Universities Retirement System, the Teachers' Retirement System of the State of Illinois, or the Judges Retirement System of Illinois and (ii) qualify as annuitants under subsection (b) of Section 3 of this Act), survivors (including individuals who (i) receive an annuity as a survivor of an individual who participated in the General Assembly Retirement System, the State Employees' Retirement System of Illinois, the State Universities Retirement System, the Teachers' Retirement System of the State of Illinois, or the Judges Retirement System of Illinois and (ii) qualify as survivors under subsection (q) of Section 3 of this Act), and

retired employees (as defined in subsection (p) of Section 3 of this Act). The remainder of the cost of coverage for each annuitant, survivor, or retired employee, as determined by the Director of Central Management Services, shall be the responsibility of that annuitant, survivor, or retired employee.

Contributions required of annuitants, survivors, and retired employees shall be the same for all retirement systems and shall also be based on whether an individual has made an election under Section 15-135.1 of the Illinois Pension Code. Contributions may be based on annuitants', survivors', or retired employees' Medicare eligibility, but may not be based on Social Security eligibility.

(a-9) No later than May 1 of each calendar year, the Director of Central Management Services shall certify in writing to the Executive Secretary of the State Employees' Retirement System of Illinois the amounts of the Medicare supplement health care premiums and the amounts of the health care premiums for all other retirees who are not Medicare eligible.

A separate calculation of the premiums based upon the actual cost of each health care plan shall be so certified.

The Director of Central Management Services shall provide to the Executive Secretary of the State Employees' Retirement System of Illinois such information, statistics, and other data as he or she may require to review the premium amounts

certified by the Director of Central Management Services.

The Department of Central Management Services, or any successor agency designated to procure healthcare contracts pursuant to this Act, is authorized to establish funds, separate accounts provided by any bank or banks as defined by the Illinois Banking Act, or separate accounts provided by any savings and loan association or associations as defined by the Illinois Savings and Loan Act of 1985 to be held by the Director, outside the State treasury, for the purpose of receiving the transfer of moneys from the Local Government Health Insurance Reserve Fund. The Department may promulgate rules further defining the methodology for the transfers. Any interest earned by moneys in the funds or accounts shall inure to the Local Government Health Insurance Reserve Fund. The transferred moneys, and interest accrued thereon, shall be used exclusively for transfers to administrative service organizations or their financial institutions for payments of claims to claimants and providers under the self-insurance health plan. The transferred moneys, and interest accrued thereon, shall not be used for any other purpose including, but not limited to, reimbursement of administration fees due the administrative service organization pursuant to its contract or contracts with the Department.

(a-10) To the extent that participation, benefits, or premiums under this Act are based on a person's service credit under an Article of the Illinois Pension Code, service credit

terminated in exchange for an accelerated pension benefit payment under Section 14-147.5, 15-185.5, or 16-190.5 of that Code shall be included in determining a person's service credit for the purposes of this Act.

(b) State employees who become eligible for this program on or after January 1, 1980 in positions normally requiring actual performance of duty not less than 1/2 of a normal work period but not equal to that of a normal work period, shall be given the option of participating in the available program. If the employee elects coverage, the State shall contribute on behalf of such employee to the cost of the employee's benefit and any applicable dependent supplement, that sum which bears the same percentage as that percentage of time the employee regularly works when compared to normal work period.

(c) The basic non-contributory coverage from the basic program of group health benefits shall be continued for each employee not in pay status or on active service by reason of (1) leave of absence due to illness or injury, (2) authorized educational leave of absence or sabbatical leave, or (3) military leave. This coverage shall continue until expiration of authorized leave and return to active service, but not to exceed 24 months for leaves under item (1) or (2). This 24-month limitation and the requirement of returning to active service shall not apply to persons receiving ordinary or accidental disability benefits or retirement benefits through the appropriate State retirement system or benefits under the

Workers' Compensation or Occupational Disease Act.

(d) The basic group life insurance coverage shall continue, with full State contribution, where such person is (1) absent from active service by reason of disability arising from any cause other than self-inflicted, (2) on authorized educational leave of absence or sabbatical leave, or (3) on military leave.

(e) Where the person is in non-pay status for a period in excess of 30 days or on leave of absence, other than by reason of disability, educational or sabbatical leave, or military leave, such person may continue coverage only by making personal payment equal to the amount normally contributed by the State on such person's behalf. Such payments and coverage may be continued: (1) until such time as the person returns to a status eligible for coverage at State expense, but not to exceed 24 months or (2) until such person's employment or annuitant status with the State is terminated (exclusive of any additional service imposed pursuant to law).

(f) The Department shall establish by rule the extent to which other employee benefits will continue for persons in non-pay status or who are not in active service.

(g) The State shall not pay the cost of the basic non-contributory group life insurance, program of health benefits and other employee benefits for members who are survivors as defined by paragraphs (1) and (2) of subsection (q) of Section 3 of this Act. The costs of benefits for these

survivors shall be paid by the survivors or by the University of Illinois Cooperative Extension Service, or any combination thereof. However, the State shall pay the amount of the reduction in the cost of participation, if any, resulting from the amendment to subsection (a) made by this amendatory Act of the 91st General Assembly.

(h) Those persons occupying positions with any department as a result of emergency appointments pursuant to Section 8b.8 of the Personnel Code who are not considered employees under this Act shall be given the option of participating in the programs of group life insurance, health benefits and other employee benefits. Such persons electing coverage may participate only by making payment equal to the amount normally contributed by the State for similarly situated employees. Such amounts shall be determined by the Director. Such payments and coverage may be continued until such time as the person becomes an employee pursuant to this Act or such person's appointment is terminated.

(i) Any unit of local government within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a unit of local government must agree to enroll all of its employees, who may select coverage under any either ~~the State~~ group health benefits plan made available by the Department under the health benefits program established under

this Section or a health maintenance organization that has contracted with the State to be available as a health care provider for employees as defined in this Act. A unit of local government must remit the entire cost of providing coverage under the health benefits program established under this Section ~~the State group health benefits plan~~ or, for coverage under a health maintenance organization, an amount determined by the Director based on an analysis of the sex, age, geographic location, or other relevant demographic variables for its employees, except that the unit of local government shall not be required to enroll those of its employees who are covered spouses or dependents under the State group health benefits ~~this~~ plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the unit of local government attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 50% of the employees are enrolled and the unit of local government remits the entire cost of providing coverage to those employees, except that a participating school district must have enrolled at least 50% of its full-time employees who have not waived coverage under the district's group health plan by participating in a component of the district's cafeteria plan. A participating school district is not required to enroll a full-time employee who has waived coverage under the district's health plan, provided that an appropriate official

from the participating school district attests that the full-time employee has waived coverage by participating in a component of the district's cafeteria plan. For the purposes of this subsection, "participating school district" includes a unit of local government whose primary purpose is education as defined by the Department's rules.

Employees of a participating unit of local government who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A participating unit of local government may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the unit of local government, its employees, or some combination of the two as determined by the unit of local government. The unit of local government shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine monthly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages, or contributed by the State for basic insurance coverages on behalf of its employees, adjusted for differences between State

employees and employees of the local government in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the unit of local government and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the unit of local government.

In the case of coverage of local government employees under a health maintenance organization, the Director shall annually determine for each participating unit of local government the maximum monthly amount the unit may contribute toward that coverage, based on an analysis of (i) the age, sex, geographic location, and other relevant demographic variables of the unit's employees and (ii) the cost to cover those employees under the State group health benefits plan. The Director may similarly determine the maximum monthly amount each unit of local government may contribute toward coverage of its employees' dependents under a health maintenance organization.

Monthly payments by the unit of local government or its employees for group health benefits plan or health maintenance organization coverage shall be deposited in the Local Government Health Insurance Reserve Fund.

The Local Government Health Insurance Reserve Fund is

hereby created as a nonappropriated trust fund to be held outside the State Treasury, with the State Treasurer as custodian. The Local Government Health Insurance Reserve Fund shall be a continuing fund not subject to fiscal year limitations. The Local Government Health Insurance Reserve Fund is not subject to administrative charges or charge-backs, including but not limited to those authorized under Section 8h of the State Finance Act. All revenues arising from the administration of the health benefits program established under this Section shall be deposited into the Local Government Health Insurance Reserve Fund. Any interest earned on moneys in the Local Government Health Insurance Reserve Fund shall be deposited into the Fund. All expenditures from this Fund shall be used for payments for health care benefits for local government and rehabilitation facility employees, annuitants, and dependents, and to reimburse the Department or its administrative service organization for all expenses incurred in the administration of benefits. No other State funds may be used for these purposes.

A local government employer's participation or desire to participate in a program created under this subsection shall not limit that employer's duty to bargain with the representative of any collective bargaining unit of its employees.

(j) Any rehabilitation facility within the State of Illinois may apply to the Director to have its employees,

annuitants, and their eligible dependents provided group health coverage under this Act on a non-insured basis. To participate, a rehabilitation facility must agree to enroll all of its employees and remit the entire cost of providing such coverage for its employees, except that the rehabilitation facility shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the rehabilitation facility attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 50% of the employees are enrolled and the rehabilitation facility remits the entire cost of providing coverage to those employees. Employees of a participating rehabilitation facility who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A participating rehabilitation facility may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the rehabilitation facility, its employees, or some combination of the 2 as determined by the rehabilitation facility. The rehabilitation facility shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine quarterly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the rehabilitation facility in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the rehabilitation facility and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the rehabilitation facility.

Monthly payments by the rehabilitation facility or its employees for group health benefits shall be deposited in the Local Government Health Insurance Reserve Fund.

(k) Any domestic violence shelter or service within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a domestic violence shelter or service must agree to enroll all of its employees and pay the entire cost of providing such coverage for its employees. The domestic

violence shelter shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the domestic violence shelter attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan and (2) at least 50% of the employees are enrolled and the domestic violence shelter remits the entire cost of providing coverage to those employees. Employees of a participating domestic violence shelter who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, or special circumstance as defined by the Director or during the annual Benefit Choice Period. A participating domestic violence shelter may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with employees, or some combination of the 2 as determined by the domestic violence shelter or service. The domestic violence shelter or service shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

- (1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its

employees, adjusted for differences between State employees and employees of the domestic violence shelter or service in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the domestic violence shelter or service and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the domestic violence shelter or service.

Monthly payments by the domestic violence shelter or service or its employees for group health insurance shall be deposited in the Local Government Health Insurance Reserve Fund.

(1) A public community college or entity organized pursuant to the Public Community College Act may apply to the Director initially to have only annuitants not covered prior to July 1, 1992 by the district's health plan provided health coverage under this Act on a non-insured basis. The community college must execute a 2-year contract to participate in the Local Government Health Plan. Any annuitant may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

The Director shall annually determine monthly rates of

payment subject to the following constraints: for those community colleges with annuitants only enrolled, first year rates shall be equal to the average cost to cover claims for a State member adjusted for demographics, Medicare participation, and other factors; and in the second year, a further adjustment of rates shall be made to reflect the actual first year's claims experience of the covered annuitants.

(l-5) The provisions of subsection (l) become inoperative on July 1, 1999.

(m) The Director shall adopt any rules deemed necessary for implementation of this amendatory Act of 1989 (Public Act 86-978).

(n) Any child advocacy center within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a child advocacy center must agree to enroll all of its employees and pay the entire cost of providing coverage for its employees. The child advocacy center shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the child advocacy center attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan and (2) at least 50% of the employees are enrolled and the

child advocacy center remits the entire cost of providing coverage to those employees. Employees of a participating child advocacy center who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, or special circumstance as defined by the Director or during the annual Benefit Choice Period. A participating child advocacy center may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the child advocacy center, its employees, or some combination of the 2 as determined by the child advocacy center. The child advocacy center shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the child advocacy center in age, sex, geographic location, or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the child advocacy center and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the child advocacy center.

Monthly payments by the child advocacy center or its employees for group health insurance shall be deposited into the Local Government Health Insurance Reserve Fund.

(Source: P.A. 100-587, eff. 6-4-18.)

(5 ILCS 375/13) (from Ch. 127, par. 533)

Sec. 13. There is established a Group Insurance Premium Fund administered by the Director which shall include: (1) amounts paid by covered members for optional life insurance and (2) refunds which may be received from (a) the group carrier or carriers which may result from favorable experience as described in Section 12 herein or (b) from any other source from which the State is reasonably and properly entitled to refund as a result of the life insurance program. The Group Insurance Premium Fund shall be a continuing fund not subject to fiscal year limitations.

The State of Illinois shall at least once each month make payment on behalf of each member, except one who is a member by virtue of participation in a program created under subsection (i), (j), (k), or (l) of Section 10 of this Act, to the appropriate carrier or, if applicable, carriers insuring State members under the contracted group life insurance program authorized by this Act.

Refunds to members for premiums paid for optional life insurance coverage may be paid from the Group Insurance Premium Fund without regard to the fact that the premium being refunded may have been paid in a different fiscal year.

(Source: P.A. 95-632, eff. 9-25-07.)

(5 ILCS 375/13.1) (from Ch. 127, par. 533.1)

Sec. 13.1. (a) All contributions, appropriations, interest, and dividend payments to fund the program of health benefits and other employee benefits, and all other revenues arising from the administration of any employee health benefits program, shall be deposited in a trust fund outside the State Treasury, with the State Treasurer as ex-officio custodian, to be known as the Health Insurance Reserve Fund.

(b) Upon the adoption of a self-insurance health plan, any monies attributable to the group health insurance program shall be deposited in or transferred to the Health Insurance Reserve Fund for use by the Department. As of the effective date of this amendatory Act of 1986, the Department shall certify to the Comptroller the amount of money in the Group Insurance Premium Fund attributable to the State group health insurance program and the Comptroller shall transfer such money from the Group Insurance Premium Fund to the Health Insurance Reserve Fund. Contributions by the State to the Health Insurance Reserve Fund to meet the requirements of this Act, as established by the Director, from the General Revenue

Fund and the Road Fund to the Health Insurance Reserve Fund shall be by annual appropriations, and all other contributions to meet the requirements of the programs of health benefits or other employee benefits shall be deposited in the Health Insurance Reserve Fund. The Department shall draw the appropriation from the General Revenue Fund and the Road Fund from time to time as necessary to make expenditures authorized under this Act.

The Director may employ such assistance and services and may purchase such goods as may be necessary for the proper development and administration of any of the benefit programs authorized by this Act. The Director may promulgate rules and regulations in regard to the administration of these programs.

All monies received by the Department for deposit in or transfer to the Health Insurance Reserve Fund, through appropriation or otherwise, shall be used to provide for the making of payments to claimants and providers and to reimburse the Department for all expenses directly incurred relating to Department development and administration of the program of health benefits and other employee benefits.

Any administrative service organization administering any self-insurance health plan and paying claims and benefits under authority of this Act may receive, pursuant to written authorization and direction of the Director, an initial transfer and periodic transfers of funds from the Health Insurance Reserve Fund in amounts determined by the Director

who may consider the amount recommended by the administrative service organization. Notwithstanding any other statute, such transferred funds shall be retained by the administrative service organization in a separate account provided by any bank as defined by the Illinois Banking Act. The Department may promulgate regulations further defining the banks authorized to accept such funds and all methodology for transfer of such funds. Any interest earned by monies in such account shall inure to the Health Insurance Reserve Fund, shall remain in such account and shall be used exclusively to pay claims and benefits under this Act. Such transferred funds shall be used exclusively for administrative service organization payment of claims to claimants and providers under the self-insurance health plan by the drawing of checks against such account. The administrative service organization may not use such transferred funds, or interest accrued thereon, for any other purpose including, but not limited to, reimbursement of administrative expenses or payments of administration fees due the organization pursuant to its contract or contracts with the Department of Central Management Services.

The account of the administrative service organization established under this Section, any transfers from the Health Insurance Reserve Fund to such account and the use of such account and funds shall be subject to (1) audit by the Department or private contractor authorized by the Department

to conduct audits, and (2) post audit pursuant to the Illinois State Auditing Act.

The Department of Central Management Services, or any successor agency designated to procure healthcare contracts pursuant to this Act, is authorized to establish funds, separate accounts provided by any bank or banks as defined by the Illinois Banking Act, or separate accounts provided by any savings and loan association or associations as defined by the Illinois Savings and Loan Act of 1985 to be held by the Director, outside the State treasury, for the purpose of receiving the transfer of moneys from the Health Insurance Reserve Fund. The Department may promulgate rules further defining the methodology for the transfers. Any interest earned by monies in the funds or accounts shall inure to the Health Insurance Reserve Fund. The transferred moneys, and interest accrued thereon, shall be used exclusively for transfers to administrative service organizations or their financial institutions for payments of claims to claimants and providers under the self-insurance health plan. The transferred moneys, and interest accrued thereon, shall not be used for any other purpose including, but not limited to, reimbursement of administration fees due the administrative service organization pursuant to its contract or contracts with the Department.

(c) The Director, with the advice and consent of the Commission, shall establish premiums for optional coverage for

dependents of eligible members for the health plans. The eligible members shall be responsible for their portion of such optional premium. The State shall contribute an amount per month for each eligible member who has enrolled one or more dependents under the health plans. Such contribution shall be made directly to the Health Insurance Reserve Fund. Those employees described in subsection (b) of Section 9 of this Act shall be allowed to continue in the health plan by making personal payments with the premiums to be deposited in the Health Insurance Reserve Fund.

(d) The Health Insurance Reserve Fund shall be a continuing fund not subject to fiscal year limitations. All expenditures from that fund shall be at the direction of the Director and shall be only for the purpose of:

(1) the payment of administrative expenses incurred by the Department for the program of health benefits or other employee benefit programs, including but not limited to the costs of audits or actuarial consultations, professional and contractual services, electronic data processing systems and services, and expenses in connection with the development and administration of such programs;

(2) the payment of administrative expenses incurred by an ~~the~~ Administrative Service Organization;

(3) the payment of health benefits;

(3.5) the payment of medical expenses incurred by the

Department for the treatment of employees who suffer accidental injury or death within the scope of their employment;

(4) refunds to employees for erroneous payments of their selected health insurance ~~dependent~~ coverage;

(5) payment of premium for stop-loss or re-insurance;

(6) payment of premium to health maintenance organizations pursuant to Section 6.1 of this Act;

(7) payment of adoption program benefits; and

(8) payment of other benefits offered to members and dependents under this Act.

(Source: P.A. 98-488, eff. 8-16-13.)

Section 10. The Illinois Pension Code is amended by changing Section 15-158.3 as follows:

(40 ILCS 5/15-158.3)

Sec. 15-158.3. Reports on cost reduction; effect on retirement at any age with 30 years of service.

(a) On or before November 15, 2001 and on or before November 15th of each year thereafter, the Board shall have the System's actuary prepare a report showing, on a fiscal year by fiscal year basis, the actual rate of participation in the self-managed plan authorized by Section 15-158.2, (i) by employees of the System's covered higher educational institutions who were hired on or after the implementation

date of the self-managed plan and (ii) by other System participants.

(b) On or before November 15th of 2001 and on or before November 15th of each year thereafter, the Illinois Board of Higher Education, in conjunction with the Bureau of the Budget (now Governor's Office of Management and Budget) shall prepare a report showing, on a fiscal year by fiscal year basis, the amount by which the costs associated with compensable sick leave have been reduced as a result of the termination of compensable sick leave accrual on and after January 1, 1998 by employees of higher education institutions who are participants in the System.

(c) (Blank). ~~On or before November 15 of 2001 and on or before November 15th of each year thereafter, the Department of Central Management Services shall prepare a report showing, on a fiscal year by fiscal year basis, the amount by which the State's cost for health insurance coverage under the State Employees Group Insurance Act of 1971 for retirees of the State's universities and their survivors has declined as a result of requiring some of those retirees and survivors to contribute to the cost of their basic health insurance. These year by year reductions in cost must be quantified both in dollars and as a level percentage of payroll covered by the System.~~

(d) The report ~~reports~~ required under subsection ~~subsections~~ (b) and (c) shall be disseminated to the Board,

the Pension Laws Commission (until it ceases to exist), the Commission on Government Forecasting and Accountability, the Illinois Board of Higher Education, and the Governor.

(e) The report ~~reports~~ required under subsection ~~subsections~~ (b) ~~and (c)~~ shall be taken into account by the Pension Laws Commission (or its successor, the Commission on Government Forecasting and Accountability) in making any recommendation to extend by legislation beyond December 31, 2002 the provision that allows a System participant to retire at any age with 30 or more years of service as authorized in Section 15-135.

(Source: P.A. 95-83, eff. 8-13-07.)

Section 99. Effective date. This Act takes effect July 1, 2021.