AN ACT concerning regulation.

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 Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, and 356z.53 ~~and 356z.43~~ of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all

other requirements of this Section shall be enforced by the Department of Central Management Services.

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

(Source: P.A. 101-13, eff. 6-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; revised 10-26-21.)

Section 10. The Illinois Insurance Code is amended by changing Section 356c and by adding Section 356z.53 as follows:

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

Sec. 356c. (1) No policy of accident and health insurance providing coverage of hospital expenses or medical expenses or both on an expense incurred basis which in addition to covering the insured, also covers members of the insured's immediate family, shall contain any disclaimer, waiver or other limitation of coverage relative to the hospital or

medical coverage or insurability of newborn infants from and after the moment of birth.

(2) Each such policy of accident and health insurance shall contain a provision stating that the accident and health insurance benefits applicable for children shall be granted immediately with respect to a newly born child from the moment of birth. The coverage for newly born children shall include coverage of illness, injury, congenital defects (including the treatment of cleft lip and cleft palate), birth abnormalities and premature birth.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period and may require payment of the appropriate premium.

(4) In the event that no other members of the insured's immediate family are covered, immediate coverage for the first newborn infant shall be provided if the insured applies for dependent's coverage within 31 days of the newborn's birth. Such coverage shall be contingent upon payment of the additional premium.

(5) The requirements of this Section shall apply, on or after the sixtieth day following the effective date of this Section, (a) to all such non-group policies delivered or issued for delivery, and (b) to all such group policies

delivered, issued for delivery, renewed or amended. The insurers of such non-group policies in effect on the sixtieth day following the effective date of this Section shall extend to owners of said policies, on or before the first policy anniversary following such date, the opportunity to apply for the addition to their policies of a provision as set forth in paragraph (2) above, with, at the option of the insurer, payment of a premium appropriate thereto.

(Source: P.A. 85-220.)

(215 ILCS 5/356z.53 new)

Sec. 356z.53. Coverage for cleft lip and cleft palate.

(a) As used in this Section, "medically necessary care and treatment" to address congenital anomalies associated with a cleft lip or palate, or both, includes:

(1) oral and facial surgery, including reconstructive services and procedures necessary to improve and restore and maintain vital functions;

(2) prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) orthodontic treatment and management;

(4) prosthodontic treatment and management; and

(5) otolaryngology treatment and management.

"Medically necessary care and treatment" does not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve

appearance.

(b) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall provide coverage for the medically necessary care and treatment of cleft lip and palate for children under the age of 19. Coverage for cleft lip and palate care and treatment may impose the same deductible, coinsurance, or other cost-sharing limitation that is imposed on other related surgical benefits under the policy.

(c) This Section does not apply to a policy that covers only dental care.

Section 99. Effective date. This Act takes effect January 1, 2024.