



SENATE JOURNAL

STATE OF ILLINOIS

**ONE HUNDRED FOURTH GENERAL
ASSEMBLY**

44TH LEGISLATIVE DAY

THURSDAY, MAY 8, 2025

12:16 O'CLOCK P.M.

SENATE
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The Senate met pursuant to adjournment.
Senator Kimberly A. Lightford, Maywood, Illinois, presiding.
Prayer by Pastor Stephen Lawrence, Exodus Church, Springfield, Illinois.
Senator Johnson led the Senate in the Pledge of Allegiance.

Senator Glowiak Hilton moved that reading and approval of the Journal of Wednesday, May 7, 2025, be postponed, pending arrival of the printed Journal.
The motion prevailed.

REPORTS RECEIVED

The Secretary placed before the Senate the following reports:

Reporting Requirement of 50 ILCS 707/15 (Law Enforcement Camera Grant Act) - 2020, submitted by the Canton Police Department.

Reporting Requirement of 50 ILCS 707/15 (Law Enforcement Camera Grant Act) - 2021, submitted by the Canton Police Department.

Reporting Requirement of 50 ILCS 707/15 (Law Enforcement Camera Grant Act) - 2022, submitted by the Canton Police Department.

Reporting Requirement of 50 ILCS 707/15 (Law Enforcement Camera Grant Act) - 2023, submitted by the Canton Police Department.

Reporting Requirement of 50 ILCS 707/20 (Law Enforcement Camera Grant Act), submitted by the Rolling Meadows Police Department.

Reporting Requirement of 50 ILCS 707/20 (Law Enforcement Camera Grant Act), submitted by the Jackson County Sheriff's Office.

GOMB Quarterly Capital Projects Review Q3 FY25, submitted by the Governor's Office of Management and Budget.

The foregoing reports were ordered received and placed on file in the Secretary's Office.

PRESENTATION OF CELEBRATION OF LIFE RESOLUTION

SENATE RESOLUTION NO. 303

Offered by Senator Anderson and all Senators:
Mourns the death of Kenneth Eugene "Kenny" McNeely.

By unanimous consent, the foregoing resolution was referred to the Resolutions Consent Calendar.

PRESENTATION OF CONGRATULATORY RESOLUTION

SENATE RESOLUTION NO. 302

Offered by Senator Cunningham:
Congratulates the Technology & Manufacturing Association (TMA) on its 100th anniversary of leading and supporting small and midsize manufacturers.

Under the Rules, the foregoing resolution was referred to the Committee on Assignments.

[May 8, 2025]

REPORTS FROM STANDING COMMITTEES

Senator Joyce, Chair of the Committee on State Government, to which was referred **House Bill No. 3493**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Joyce, Chair of the Committee on State Government, to which was referred **House Bill No. 1631**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Glowiak Hilton, Chair of the Committee on Licensed Activities, to which was referred **Senate Bill No. 2469**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Glowiak Hilton, Chair of the Committee on Licensed Activities, to which was referred **House Bills Numbered 2517, 3373, 3487 and 3850**, reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Glowiak Hilton, Chair of the Committee on Licensed Activities, to which was referred the following Senate floor amendments, reported that the Committee recommends do adopt:

Senate Amendment No. 1 to House Bill 1365

Senate Amendment No. 1 to House Bill 3356

Under the rules, the foregoing floor amendments are eligible for consideration on second reading.

Senator Castro, Chair of the Committee on Executive, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

Senate Amendment No. 1 to Senate Bill 2319

Under the rules, the foregoing floor amendment is eligible for consideration on second reading.

Senator Castro, Chair of the Committee on Executive, to which was referred **House Bill No. 2667**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Castro, Chair of the Committee on Executive, to which was referred **House Bill No. 2947**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Johnson, Chair of the Committee on Local Government, to which was referred **Senate Bill No. 2303**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Johnson, Chair of the Committee on Local Government, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

Senate Amendment No. 2 to Senate Bill 637

Under the rules, the foregoing floor amendment is eligible for consideration on second reading.

Senator Johnson, Chair of the Committee on Local Government, to which was referred **House Bills Numbered 663, 1615, 1908, 2142, 2336, 2757 and 3141**, reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Johnson, Chair of the Committee on Local Government, to which was referred **House Bill No. 2139**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Hastings, Chair of the Committee on Judiciary, to which was referred **Senate Bill No. 2001**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Hastings, Chair of the Committee on Judiciary, to which was referred the following Senate floor amendments, reported that the Committee recommends do adopt:

Senate Amendment No. 2 to Senate Bill 1486

Senate Amendment No. 3 to Senate Bill 2253

Under the rules, the foregoing floor amendments are eligible for consideration on second reading.

Senator Hastings, Chair of the Committee on Judiciary, to which was referred **House Bills Numbered 1083, 1364, 1605, 1628, 1842, 2462, 3281 and 3566**, reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Hastings, Chair of the Committee on Judiciary, to which was referred **House Bills Numbered 2562 and 3616**, reported the same back with amendments having been adopted thereto, with the recommendation that the bills, as amended, do pass.

Under the rules, the bills were ordered to a second reading.

Senator Faraci, Chair of the Committee on Commerce, to which was referred **Senate Resolution No. 83**, reported the same back with the recommendation that the resolution be adopted.

Under the rules, **Senate Resolution No. 83** was placed on the Secretary's Desk.

Senator Faraci, Chair of the Committee on Commerce, to which was referred **Senate Joint Resolution No. 16**, reported the same back with the recommendation that the resolution be adopted.

Under the rules, **Senate Joint Resolution No. 16** was placed on the Secretary's Desk.

Senator Faraci, Chair of the Committee on Commerce, to which was referred **House Bill No. 3187**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Joyce, Vice-Chair of the Committee on Agriculture, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

[May 8, 2025]

Senate Amendment No. 2 to Senate Bill 783

Under the rules, the foregoing floor amendment is eligible for consideration on second reading.

Senator Joyce, Vice-Chair of the Committee on Agriculture, to which was referred **House Bill No. 2196**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Joyce, Vice-Chair of the Committee on Agriculture, to which was referred **House Bill No. 3760**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Preston, Chair of the Committee on Consumer Protection, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

Senate Amendment No. 2 to Senate Bill 314

Under the rules, the foregoing floor amendment is eligible for consideration on second reading.

Senator Preston, Chair of the Committee on Consumer Protection, to which was referred **House Bill No. 2338**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Ellman, Chair of the Committee on Environment and Conservation, to which was referred **House Bill No. 2366**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Ellman, Chair of the Committee on Environment and Conservation, to which was referred **House Bill No. 2419**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Stadelman, Chair of the Committee on Energy and Public Utilities, to which was referred **House Bills Numbered 2435 and 3510**, reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Stadelman, Chair of the Committee on Energy and Public Utilities, to which was referred **House Bills Numbered 1062, 1866 and 3725**, reported the same back with amendments having been adopted thereto, with the recommendation that the bills, as amended, do pass.

Under the rules, the bills were ordered to a second reading.

LEGISLATIVE MEASURE FILED

The following Floor amendment to the Senate Bill listed below has been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 3 to Senate Bill 1486

READING BILL FROM THE HOUSE OF REPRESENTATIVES A FIRST TIME

House Bill No. 3065, sponsored by Senator Harmon, was taken up, read by title a first time and referred to the Committee on Assignments.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator Villivalam, **House Bill No. 1226** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Morrison, **House Bill No. 1365** having been printed, was taken up and read by title a second time.

Senator Morrison offered the following amendment and moved its adoption:

AMENDMENT NO. 1 TO HOUSE BILL 1365

AMENDMENT NO. 1. Amend House Bill 1365 on page 16, immediately below line 19, by inserting the following:

"Section 23. The Illinois Occupational Therapy Practice Act is amended by adding Section 8.1 as follows:

(225 ILCS 75/8.1 new)

Sec. 8.1. Practice pending licensure.

(a) An applicant for licensure under this Act shall be authorized to temporarily practice under supervision pending issuance of a license if: (1) the applicant authorizes the Department to release information regarding the application's status; and (2) the Department acknowledges that the application has been received, which may be proven by the applicant providing the employer with a copy of the Department's license application screen that shows that the application is pending.

(b) Temporary authorization to practice under this Section shall immediately terminate upon: (1) a determination by the Department that, based upon review of the application and supporting documents, the applicant does not meet the requirements for licensure; (2) a determination by the Department that the applicant has engaged in conduct or actions that would constitute grounds for discipline under this Act; or (3) the issuance of a permanent license."

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Preston, **House Bill No. 1366** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Aquino, **House Bill No. 1430** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Stadelman, **House Bill No. 1431** having been printed, was taken up and read by title a second time.

Senator Stadelman offered the following amendment and moved its adoption:

AMENDMENT NO. 1 TO HOUSE BILL 1431

AMENDMENT NO. 1. Amend House Bill 1431 on page 1, line 5, after "12", by inserting "and by changing Section 55"; and

on page 1, immediately below line 17, by inserting the following:

"(210 ILCS 88/55)

Sec. 55. Enforcement.

[May 8, 2025]

(a) The Attorney General is responsible for administering and ensuring compliance with this Act, including the development of any rules necessary for the implementation and enforcement of this Act.

(b) The Attorney General shall develop and implement a process for receiving and handling complaints from individuals or hospitals regarding possible violations of this Act.

(c) The Attorney General may conduct any investigation deemed necessary regarding possible violations of this Act by any hospital including, without limitation, the issuance of subpoenas to: (i) require the hospital to file a statement or report or answer interrogatories in writing as to all information relevant to the alleged violations; (ii) examine under oath any person who possesses knowledge or information directly related to the alleged violations; and (iii) examine any record, book, document, account, or paper necessary to investigate the alleged violation.

(d) If the Attorney General determines that there is a reason to believe that any hospital has violated the Act, the Attorney General may bring an action in the name of the People of the State against the hospital to obtain temporary, preliminary, or permanent injunctive relief for any act, policy, or practice by the hospital that violates this Act. Before bringing such an action, the Attorney General may permit the hospital to submit a Correction Plan for the Attorney General's approval.

(e) This Section applies if:

(i) a court orders a party to make payments to the Attorney General and the payments are to be used for the operations of the Office of the Attorney General; or

(ii) a party agrees in a Correction Plan under this Act, to make payments to the Attorney General for the operations of the Office of the Attorney General.

(f) Moneys paid under any of the conditions described in (e) shall be deposited into the Attorney General Court Ordered and Voluntary Compliance Payment Projects Fund. Moneys in the Fund shall be used, subject to appropriation, for the performance of any function pertaining to the exercise of the duties to the Attorney General including, but not limited to, enforcement of any law of this State and conducting public education programs; however, any moneys in the Fund that are required by the court to be used for a particular purpose shall be used for that purpose.

(g) The Attorney General may seek the assessment of one or more of the following civil monetary penalties in any action filed under this Act where the hospital knowingly violates the Act:

(1) For violations, involving a pattern or practice, of not providing the information to patients under Sections 12, 15, 20, 25, and 50, the civil monetary penalty shall not exceed \$500 per violation.

(2) For violations involving the failure to engage in or refrain from certain activities under Sections 30, 35 and 40, the civil monetary penalty shall not exceed \$1000 per violation.

(h) In the event a court grants a final order of relief against any hospital for a violation of this Act, the Attorney General may, after all appeal rights have been exhausted, refer the hospital to the Illinois Department of Public Health for possible adverse licensure action under the Hospital Licensing Act. (Source: P.A. 94-885, eff. 1-1-07)."

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Preston, **House Bill No. 1575** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator DeWitte, **House Bill No. 1648** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Peters, **House Bill No. 1710** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Peters, **House Bill No. 1715** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Loughran Cappel, **House Bill No. 1787** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Koehler, **House Bill No. 2337** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Edly-Allen, **House Bill No. 2346** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Public Health, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 2346

AMENDMENT NO. 1. Amend House Bill 2346 on page 5, by replacing lines 18 through 21 with the following:

"(b) Pharmacy recipients shall notify the Department of their participation in the dispensing of drugs under this Act and shall report any data required in a reasonable format established by the Department."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Arellano Jr., **House Bill No. 2362** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 2390** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Education, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 2390

AMENDMENT NO. 1. Amend House Bill 2390 on page 16, immediately below line 19, by inserting the following:

"A school district that meets all of the requirements of this subsection (j) shall be withdrawn from the joint agreement on the date that the school district specifies in both the notice sent to other school districts pursuant to the joint agreement and the resolution passed by the board as long as the notice was given at least 18 months before, as specified in paragraph (1) of this subsection (j), the date specified."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Villivalam, **House Bill No. 2409** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Guzmán, **House Bill No. 2418** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 2464** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Hastings, **House Bill No. 2506** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Cervantes, **House Bill No. 2546** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Arellano Jr., **House Bill No. 2547** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Faraci, **House Bill No. 2572** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Rose, **House Bill No. 1754** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Loughran Cappel, **House Bill No. 2602** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Villa, **House Bill No. 2774** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator S. Turner, **House Bill No. 2801** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Halpin, **House Bill No. 2873** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Koehler, **House Bill No. 2877** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 2962** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Koehler, **House Bill No. 2994** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Education, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 2994

AMENDMENT NO. 1. Amend House Bill 2994 by replacing everything after the enacting clause with the following:

"Section 5. The Mental Health and Developmental Disabilities Confidentiality Act is amended by changing Section 4 as follows:

(740 ILCS 110/4) (from Ch. 91 1/2, par. 804)

Sec. 4. (a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:

(1) the parent or guardian of a recipient who is under 12 years of age;

(2) the recipient if he is 12 years of age or older;

(3) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. The parent or guardian who is denied access by either the recipient or the therapist may petition a court for access to the record. Nothing in this paragraph is intended to prohibit the parent or guardian of a recipient who is at least 12 but under 18 years from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any;

(3.5) the parent or guardian of a minor, regardless of the minor's age, if the minor is involved in special education services under Section 14-1.11 of the School Code, and only for the purpose of inspecting and copying a record of the specific mental health or developmental services that the parent or guardian consented to on the recipient's behalf for special education services; or the designated representative of a student over the age of 18 involved in special education services under Section 14-6.10 of the School Code ~~the personal representative under HIPAA, 45 CFR 164.502(g), of a recipient, regardless of the age of the recipient;~~

(4) the guardian of a recipient who is 18 years or older;

(5) an attorney or guardian ad litem who represents a minor 12 years of age or older in any judicial or administrative proceeding, provided that the court or administrative hearing officer has entered an order granting the attorney this right;

(6) an agent appointed under a recipient's power of attorney for health care or for property, when the power of attorney authorizes the access;

(7) an attorney-in-fact appointed under the Mental Health Treatment Preference Declaration Act; or

(8) any person in whose care and custody the recipient has been placed pursuant to Section 3-811 of the Mental Health and Developmental Disabilities Code.

(b) Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance. A reasonable fee may be charged for duplication of a record. However, when requested to do so in writing by any indigent recipient, the custodian of the records shall provide at no charge to the recipient, or to the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act or to any other not-for-profit agency whose primary purpose is to provide free legal services or advocacy for the indigent and who has received written authorization from the recipient under Section 5 of this Act to receive his records, one copy of any records in its possession whose disclosure is authorized under this Act.

(c) Any person entitled to access to a record under this Section may submit a written statement concerning any disputed or new information, which statement shall be entered into the record. Whenever any disputed part of a record is disclosed, any submitted statement relating thereto shall accompany the disclosed part. Additionally, any person entitled to access may request modification of any part of the record which he believes is incorrect or misleading. If the request is refused, the person may seek a court order to compel modification.

(d) Whenever access or modification is requested, the request and any action taken thereon shall be noted in the recipient's record.

(e) Nothing in this Section shall be construed to affect the protection of or access to records under the Illinois School Student Records Act or the federal Individuals with Disabilities Education Act. (Source: P.A. 103-474, eff. 1-1-24.)".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Ellman, **House Bill No. 3039** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Hastings, **House Bill No. 3050** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Porfirio, **House Bill No. 3087** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Cervantes, **House Bill No. 3096** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Cervantes, **House Bill No. 3097** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Halpin, **House Bill No. 3160** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Loughran Cappel, **House Bill No. 3328** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Belt, **House Bill No. 3356** having been printed, was taken up and read by title a second time.

Senator Belt offered the following amendment and moved its adoption:

[May 8, 2025]

AMENDMENT NO. 1 TO HOUSE BILL 3356

AMENDMENT NO. 1 . Amend House Bill 3356 on page 62, lines 18 and 19, by replacing "upon becoming law" with "January 1, 2026".

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Curran, **House Bill No. 3377** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Anderson, **House Bill No. 3388** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Faraci, **House Bill No. 3500** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Education, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 3500

AMENDMENT NO. 1 . Amend House Bill 3500 on page 22, by replacing lines 18 through 23 with the following:

"meeting to the parent or guardian; -

(2) to the parent or guardian of a student for whom a Section 504 plan under the federal Rehabilitation Act of 1973 is being created at the initial Section 504 meeting or, if the student has an existing Section 504 plan, by providing the informational materials to the parent or guardian of the student using the same distribution methods employed for other communications related to the student's Section 504 plan no later than the 2026-2027 school year; and

(3) beginning with the 2026-2027 school year, by posting the informational materials on the school district's website."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Belt, **House Bill No. 3522** was taken up, read by title a second time.

Committee Amendment Nos. 1 and 2 were held in the Committee on Higher Education.

The following amendment was offered in the Committee on Higher Education, adopted and ordered printed:

AMENDMENT NO. 3 TO HOUSE BILL 3522

AMENDMENT NO. 3 . Amend House Bill 3522 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Public University Direct Admission Program Act.

Section 5. Findings. The General Assembly finds all of the following:

(1) Illinois has a strong system of public higher education, including public universities and community colleges across the State.

(2) The Illinois economy thrives when Illinois students choose to pursue postsecondary education at Illinois institutions of higher education.

(3) According to the National Bureau of Economic Research, two-thirds of graduates stay and work in the state in which they matriculated.

(4) Students who have been historically underserved, such as students who are the first in their families to go to college, students who come from low-income families or communities, students of color, and students from rural communities, among others, often face the greatest barriers to accessing higher education, in part because of a lack of information.

(5) Every eligible high school senior in Illinois should receive an offer to an Illinois institution of higher education, including public universities and community colleges.

(6) Every public community college student seeking a transfer pathway who meets the requirements should receive an offer to a public university in Illinois.

(7) Illinois can and should develop the tools and technology and partner with vendors if appropriate to dramatically simplify the public university and community college application and admission process for Illinois students.

Section 10. Definitions. As used in this Act:

"Direct admissions information" means a student's name, home address, birth date, telephone number, email address, and cumulative grade point average.

"Public university" means the University of Illinois at Springfield, Southern Illinois University, Chicago State University, Eastern Illinois University, Governors State University, Illinois State University, Northeastern Illinois University, Northern Illinois University, Western Illinois University, or any other public university established or authorized by the General Assembly after the effective date of this Act.

Section 15. Direct admission program.

(a) Beginning with the 2027-2028 academic year, the Board of Higher Education, in collaboration with the Illinois Community College Board, the Illinois Student Assistance Commission, and the State Board of Education, shall establish and administer a direct admission program. Consistent with the federal Family Educational Rights and Privacy Act of 1974, the Illinois School Student Records Act, and the School Code, the direct admission program shall automatically offer general admission into a public university or community college to qualified high school seniors in this State and to public community college students in this State who qualify to transfer to a public university.

(b) Each public university in the direct admission program shall identify and provide its grade point average standards for general admission for first time admission and for transfer students to the Illinois Student Assistance Commission by March 1 of each year. The Illinois Student Assistance Commission in collaboration with the Board of Higher Education and the Illinois Community College Board shall determine which students meet the standards for general admission for each public university in the direct admission program, and that information shall be made available to the Board of Higher Education. The Board of Higher Education or a statewide student application portal, as provided in subsections (g) and (h), shall notify the student and each public university for which the student qualifies. Each public university may also notify qualified students.

(c) Beginning July 1, 2026 and each July 1 thereafter, the Illinois Student Assistance Commission shall use data collected from school districts pursuant to Section 10-20.5a and paragraph 16 of Section 34-18 of the School Code for purposes of subsection (b) to determine which students meet the standards for general admission and provide the data to the Board of Higher Education.

(d) As all public community colleges in this State are open-access institutions, high school student direct admissions information shall be used to identify a student's local public community college. All correspondence to a student, pursuant to subsection (b), indicating the public universities that offer the student direct admission shall also indicate the student's acceptance to the community college. The public community college may also notify students within its district directly.

(e) Under the direct admission program, a public community college shall offer admission to all students who are residents of the community college district. Under the direct admission program, a public university shall offer general admission to any high school senior in this State who meets the public university's standards for admission, as identified under subsection (b), and to any public community college transfer student transferring to a public university who meets all of the following requirements:

(1) Is enrolled at a public community college in this State.

(2) Has earned a minimum of 30 graded, transferable semester hours.

(3) Meets the minimum grade point average requirement as set by the public university and as reported to Illinois Student Assistance Commission.

(f) By July 1 of each year, community college districts shall provide, on an equal basis and consistent with the federal Family Educational Rights and Privacy Act of 1974, for any student who has met the 30-hour transferable credit hour requirement set forth in paragraph (2) of subsection (e), access to community college student direct admissions information to the Illinois Community College Board. The Illinois Community College Board shall transmit this information to the Illinois Student Assistance Commission for the purpose of the direct admission program. Prior to providing the student's direct admissions information and transferable credit hours, each community college district shall receive the

written or electronic consent of the student if the student is 18 years of age or older or the student's parent of guardian if the student is younger than 18 years of age. Community college students are encouraged to consult the Illinois Articulation Initiative General Education Core Curriculum course list and other resources at the State and university level to determine course transferability for purposes of paragraph (2) of subsection (e). Community college students who have not completed a degree prior to transfer shall be notified by the public university in which they are enrolled to consult the Student Transfer Achievement Reform Act to determine if they are eligible for reverse transfer of credits for the purpose of obtaining an associate degree.

(g) The Illinois Student Assistance Commission may gather data and develop the technology to automatically notify high school seniors in this State and public community college transfer students of the direct admission program for the public universities for which those students qualify, based on the standards submitted under subsection (b) or, in the case of public community colleges, based on the community college district where those students reside.

(h) The Illinois Student Assistance Commission may use the services of a statewide student application portal and aggregator to provide the automatic notification in subsection (g). The notification shall include the student's local public community college, consistent with the requirements in subsection (d).

(i) The direct admission program shall provide admitted high school seniors in this State and public community college transfer students with the website address for the Illinois Student Assistance Commission to find information regarding State grant programs, support for financial aid application completion, scholarship searches, and other financial aid-related information and shall encourage students to determine their eligibility for financial aid by completing the Free Application for Federal Student Aid or, if applicable, an application for State financial aid.

(j) A public university or community college may verify applicant information, including transcripts, Illinois residency, and high school graduation in determining eligibility for enrollment. A public university or community college may revoke admission if an applicant does not meet the public university's or community college's direct admission criteria as specified in this Act before enrolling at the public university or community college.

(k) Students who apply to a public university or community college pursuant to this Act must not be required to pay an application fee by any public university or community college as part of the direct admission program.

(l) The Illinois Student Assistance Commission, the Board of Higher Education, the Illinois Community College Board, public universities, and community colleges may enter into data sharing agreements as necessary for the implementation of this Section.

(m) The Board of Higher Education, the Illinois Student Assistance Commission, and the Illinois Community College Board may adopt joint rules to develop procedures for the implementation of this Section.

Section 20. Access and outreach campaign. Beginning with the 2027-2028 academic year, the Board of Higher Education, in collaboration with the Illinois Student Assistance Commission and the State Board of Education, shall develop, in consultation with the University of Illinois at Chicago and the University of Illinois at Urbana-Champaign, an access and outreach campaign to inform qualifying State high school juniors and seniors about the opportunity to apply to the University of Illinois at Chicago or the University of Illinois at Urbana-Champaign. Qualifying students shall be identified and encouraged to apply in the following manner:

(1) The University of Illinois at Chicago and the University of Illinois at Urbana-Champaign shall determine the criteria by which students shall be identified for the access and outreach campaign. The University of Illinois at Chicago and the University of Illinois at Urbana-Champaign shall provide the qualifying criteria to the Illinois Student Assistance Commission, as long as the qualifying criteria is based on data available to the Illinois Student Assistance Commission, by February 1 each year.

(2) The University of Illinois at Chicago and the University of Illinois at Urbana-Champaign shall provide the Illinois Student Assistance Commission with the content of the communication to be shared with students describing how to request information on how to apply. The Illinois Student Assistance Commission may use the same portal or mechanisms for this communication as used for offers of direct admission under Section 15.

(3) The Illinois Student Assistance Commission, in collaboration with the Board of Higher Education and the State Board of Education, shall provide the University of Illinois at Chicago and the University of Illinois at Urbana-Champaign with the direct admissions information of the students who meet the qualifying criteria defined by the University of Illinois at Chicago or the University of Illinois at Urbana-Champaign.

(4) The Board of Higher Education and the Illinois Student Assistance Commission may adopt any rules necessary to administer this Section.

Section 25. Direct admission program and access and outreach campaign report.

(a) In establishing the direct admission program, the Board of Higher Education, in collaboration with the Illinois Community College Board, shall specifically evaluate the impact on enrollment of low-income students, students of color, first generation students, students from populations underserved in higher education, and students from rural areas of this State.

(b) The Board of Higher Education shall submit a report on the direct admission program and the access and outreach campaign to the Governor and General Assembly by August 1, 2029 and each August 1 thereafter. The report shall include, but is not limited to, information related to implementation of the direct admission program, the demographic, as collected and available, and geographic data of students offered direct admission and the public university or community college to which direct admission was offered, the demographic, as collected and available, and geographic data of students who qualified for the access and outreach campaign by the University of Illinois at Chicago and the University of Illinois at Urbana-Champaign under Section 20, those who applied, and those who were offered admission, the demographic, as collected and available, and geographic data of high school seniors and public community college transfer students who accepted direct admission and enrolled in the public university or public community college that offered that direct admission, changes in admissions and enrollment over time of high school seniors and public community college transfer students through the direct admission program, and recommendations to improve the direct admission program. The Board of Higher Education shall collaborate with the Illinois Community College Board, the State Board of Education, the Illinois Student Assistance Commission, and public universities to collect data necessary to fulfill the reporting requirements of this Section.

(c) The Board of Higher Education, the Illinois Student Assistance Commission, and the Illinois Community College Board, may adopt any rules necessary to administer this Section.

Section 30. The School Code is amended by changing Sections 2-3.64a-5, 10-20.5a, and 34-18 as follows:

(105 ILCS 5/2-3.64a-5)

Sec. 2-3.64a-5. State goals and assessment.

(a) For the assessment and accountability purposes of this Section, "students" includes those students enrolled in a public or State-operated elementary school, secondary school, or cooperative or joint agreement with a governing body or board of control, a charter school operating in compliance with the Charter Schools Law, a school operated by a regional office of education under Section 13A-3 of this Code, or a public school administered by a local public agency or the Department of Human Services.

(b) The State Board of Education shall establish the academic standards that are to be applicable to students who are subject to State assessments under this Section. The State Board of Education shall not establish any such standards in final form without first providing opportunities for public participation and local input in the development of the final academic standards. Those opportunities shall include a well-publicized period of public comment and opportunities to file written comments.

(c) Beginning no later than the 2014-2015 school year, the State Board of Education shall annually assess all students enrolled in grades 3 through 8 in English language arts and mathematics.

Beginning no later than the 2017-2018 school year, the State Board of Education shall annually assess all students in science at one grade in grades 3 through 5, at one grade in grades 6 through 8, and at one grade in grades 9 through 12.

The State Board of Education shall annually assess schools that operate a secondary education program, as defined in Section 22-22 of this Code, in English language arts and mathematics. The State Board of Education shall administer no more than 3 assessments, per student, of English language arts and mathematics for students in a secondary education program. One of these assessments shall be recognized by this State's public institutions of higher education, as defined in the Board of Higher Education Act, for

the purpose of student application or admissions consideration. The assessment administered by the State Board of Education for the purpose of student application or admissions consideration by institutions of higher education must be administered on a school day during regular student attendance hours, and student profile information collected by the assessment shall, if available, be made available to the State's public institutions of higher education in a timely manner.

Students who do not take the State's final accountability assessment or its approved alternate assessment may not receive a regular high school diploma unless the student is exempted from taking the State assessments under subsection (d) of this Section because the student is enrolled in a program of adult and continuing education, as defined in the Adult Education Act, or the student is identified by the State Board of Education, through rules, as being exempt from the assessment.

The State Board of Education shall not assess students under this Section in subjects not required by this Section.

Districts shall inform their students of the timelines and procedures applicable to their participation in every yearly administration of the State assessments. The State Board of Education shall establish periods of time in each school year during which State assessments shall occur to meet the objectives of this Section.

The requirements of this subsection do not apply if the State Board of Education has received a waiver from the administration of assessments from the U.S. Department of Education.

(d) Every individualized educational program as described in Article 14 shall identify if the State assessment or components thereof require accommodation for the student. The State Board of Education shall develop rules governing the administration of an alternate assessment that may be available to students for whom participation in this State's regular assessments is not appropriate, even with accommodations as allowed under this Section.

Students receiving special education services whose individualized educational programs identify them as eligible for the alternative State assessments nevertheless shall have the option of also taking this State's regular final accountability assessment, which shall be administered in accordance with the eligible accommodations appropriate for meeting these students' respective needs.

All students determined to be English learners shall participate in the State assessments. The scores of those students who have been enrolled in schools in the United States for less than 12 months may not be used for the purposes of accountability. Any student determined to be an English learner shall receive appropriate assessment accommodations, including language supports, which shall be established by rule. Approved assessment accommodations must be provided until the student's English language skills develop to the extent that the student is no longer considered to be an English learner, as demonstrated through a State-identified English language proficiency assessment.

(e) The results or scores of each assessment taken under this Section shall be made available to the parents of each student.

In each school year, the scores attained by a student on the final accountability assessment must be placed in the student's permanent record pursuant to rules that the State Board of Education shall adopt for that purpose in accordance with Section 3 of the Illinois School Student Records Act. In each school year, the scores attained by a student on the State assessments administered in grades 3 through 8 must be placed in the student's temporary record.

(f) All schools shall administer the State's academic assessment of English language proficiency to all children determined to be English learners.

(g) All schools in this State that are part of the sample drawn by the National Center for Education Statistics, in collaboration with their school districts and the State Board of Education, shall administer the academic assessments under the National Assessment of Educational Progress carried out under Section 411(b)(2) of the federal National Education Statistics Act of 1994 (20 U.S.C. 9010) if the U.S. Secretary of Education pays the costs of administering the assessments.

(h) (Blank).

(i) For the purposes of this subsection (i), "academically based assessments" means assessments consisting of questions and answers that are measurable and quantifiable to measure the knowledge, skills, and ability of students in the subject matters covered by the assessments. All assessments administered pursuant to this Section must be academically based assessments. The scoring of academically based assessments shall be reliable, valid, and fair and shall meet the guidelines for assessment development and use prescribed by the American Psychological Association, the National Council on Measurement in Education, and the American Educational Research Association.

The State Board of Education shall review the use of all assessment item types in order to ensure that they are valid and reliable indicators of student performance aligned to the learning standards being assessed and that the development, administration, and scoring of these item types are justifiable in terms of cost.

(j) The State Superintendent of Education shall appoint a committee of no more than 21 members, consisting of parents, teachers, school administrators, school board members, assessment experts, regional superintendents of schools, and citizens, to review the State assessments administered by the State Board of Education. The Committee shall select one of its members as its chairperson. The Committee shall meet on an ongoing basis to review the content and design of the assessments (including whether the requirements of subsection (i) of this Section have been met), the time and money expended at the local and State levels to prepare for and administer the assessments, the collective results of the assessments as measured against the stated purpose of assessing student performance, and other issues involving the assessments identified by the Committee. The Committee shall make periodic recommendations to the State Superintendent of Education and the General Assembly concerning the assessments.

(k) The State Board of Education may adopt rules to implement this Section.

(Source: P.A. 103-204, eff. 1-1-24.)

(105 ILCS 5/10-20.5a) (from Ch. 122, par. 10-20.5a)

Sec. 10-20.5a. Access to high school campus.

(a) In this Section:

"Direct admissions information" means a student's name, home address, birth date, telephone number, email address, and cumulative grade point average.

"Directory information" means a high school student's name, home address, birth date, and telephone number.

"Public institution of higher education" has the meaning given to that term in the Board of Higher Education Act.

(a-3) For school districts maintaining grades 10 through 12, to provide, on an equal basis, and consistent with the federal Family Educational Rights and Privacy Act of 1974, access to a high school campus and student directory information to the official recruiting representatives of the armed forces of Illinois and the United States, to the Illinois Student Assistance Commission, and to State public institutions of higher education for the purpose of informing students of educational and career opportunities if the board has provided such access to persons or groups whose purpose is to acquaint students with educational or occupational opportunities available to them. The board is not required to give greater notice regarding the right of access to recruiting representatives than is given to other persons and groups. ~~In this Section, "directory information" means a high school student's name, address, and telephone number.~~

(a-5) For a school district maintaining grades 10 through 12, to provide, on an equal basis and consistent with the federal Family Educational Rights and Privacy Act of 1974 and the Illinois School Student Records Act, access to student direct admissions information to the Illinois Student Assistance Commission for the purpose of the direct admission program.

(b) If a student or his or her parent or guardian submits a signed, written request to the high school before the end of the student's sophomore year (or if the student is a transfer student, by another time set by the high school) that indicates that the student or his or her parent or guardian does not want the student's directory information to be provided to official recruiting representatives, to the Illinois Student Assistance Commission, or to public institutions of higher education under subsection (a-3) ~~(a)~~ of this Section, the high school may not provide access to the student's directory information to these recruiting representatives, the Illinois Student Assistance Commission, or public institutions of higher education. The high school shall notify its students and their parents or guardians of the provisions of this subsection (b).

(b-5) If a student who is 18 years of age or older or the parent or guardian of a student who is under 18 years of age submits a signed, written or electronic request that indicates that the student or his or her parent or guardian does permit the student's direct admissions information to be provided under subsection (a-5), the high school shall provide the student's direct admissions information to the Illinois Student Assistance Commission. The Illinois Student Assistance Commission shall provide opt-in language to school districts no later than June 30, 2025. The high school shall notify its students and their parents or guardians of the provisions of this subsection (b-5) and, at the time of school registration or at other appropriate times prior to the end of a student's junior year, give its students and their parents or guardians the option for a student's direct admissions information to be shared for the purpose of the direct admission program.

(c) A high school may require official recruiting representatives of the armed forces of Illinois and the United States to pay a fee for copying and mailing a student's directory information in an amount that is not more than the actual costs incurred by the high school.

(d) Information received by an official ~~recruiting representative~~ under this Section may be used only to provide information to students concerning educational and career opportunities and to assist in designating State Scholars under Section 25 of the Higher Education Student Assistance Act. Information may not be released to a person who is not involved in recruiting students for the armed forces of Illinois or the United States or providing educational opportunity information for the Board of Higher Education, the Illinois Community College Board, the Illinois Student Assistance Commission, or public State institutions of higher education.

(e) By July 1, 2026 and each July 1 thereafter, each school district under this Section shall make high school ~~January 1, 2024,~~ student directory information ~~shall be made~~ electronically accessible through a secure centralized data system for official recruiting representatives of the armed forces of Illinois and the United States, as well as to the Illinois Student Assistance Commission and State public institutions of higher education.

(f) By July 1, 2026 and each July 1 thereafter, each school district under this Section shall make student direct admissions information, for students graduating in the next year, electronically accessible through a secure, centralized data system for the Illinois Student Assistance Commission for the purpose of the direct admission program.

(g) The Board of Higher Education, the Illinois Community College Board, the Illinois Student Assistance Commission, and the State Board of Education may adopt any rules necessary to administer this Section.

(Source: P.A. 103-204, eff. 1-1-24.)

(105 ILCS 5/34-18) (from Ch. 122, par. 34-18)

Sec. 34-18. Powers of the board. The board shall exercise general supervision and jurisdiction over the public education and the public school system of the city, and, except as otherwise provided by this Article, shall have power:

1. To make suitable provision for the establishment and maintenance throughout the year or for such portion thereof as it may direct, not less than 9 months and in compliance with Section 10-19.05, of schools of all grades and kinds, including normal schools, high schools, night schools, schools for defectives and delinquents, parental and truant schools, schools for the blind, the deaf, and persons with physical disabilities, schools or classes in manual training, constructural and vocational teaching, domestic arts, and physical culture, vocation and extension schools and lecture courses, and all other educational courses and facilities, including establishing, equipping, maintaining and operating playgrounds and recreational programs, when such programs are conducted in, adjacent to, or connected with any public school under the general supervision and jurisdiction of the board; provided that the calendar for the school term and any changes must be submitted to and approved by the State Board of Education before the calendar or changes may take effect, and provided that in allocating funds from year to year for the operation of all attendance centers within the district, the board shall ensure that supplemental general State aid or supplemental grant funds are allocated and applied in accordance with Section 18-8, 18-8.05, or 18-8.15. To admit to such schools without charge foreign exchange students who are participants in an organized exchange student program which is authorized by the board. The board shall permit all students to enroll in apprenticeship programs in trade schools operated by the board, whether those programs are union-sponsored or not. No student shall be refused admission into or be excluded from any course of instruction offered in the common schools by reason of that student's sex. No student shall be denied equal access to physical education and interscholastic athletic programs supported from school district funds or denied participation in comparable physical education and athletic programs solely by reason of the student's sex. Equal access to programs supported from school district funds and comparable programs will be defined in rules promulgated by the State Board of Education in consultation with the Illinois High School Association. Notwithstanding any other provision of this Article, neither the board of education nor any local school council or other school official shall recommend that children with disabilities be placed into regular education classrooms unless those children with disabilities are provided with supplementary services to assist them so that they benefit from the regular classroom instruction and are included on the teacher's regular education class register;

2. To furnish lunches to pupils, to make a reasonable charge therefor, and to use school funds for the payment of such expenses as the board may determine are necessary in conducting the school lunch program;

3. To co-operate with the circuit court;

4. To make arrangements with the public or quasi-public libraries and museums for the use of their facilities by teachers and pupils of the public schools;

5. To employ dentists and prescribe their duties for the purpose of treating the pupils in the schools, but accepting such treatment shall be optional with parents or guardians;

6. To grant the use of assembly halls and classrooms when not otherwise needed, including light, heat, and attendants, for free public lectures, concerts, and other educational and social interests, free of charge, under such provisions and control as the principal of the affected attendance center may prescribe;

7. To apportion the pupils to the several schools; provided that no pupil shall be excluded from or segregated in any such school on account of his color, race, sex, or nationality. The board shall take into consideration the prevention of segregation and the elimination of separation of children in public schools because of color, race, sex, or nationality. Except that children may be committed to or attend parental and social adjustment schools established and maintained either for boys or girls only. All records pertaining to the creation, alteration or revision of attendance areas shall be open to the public. Nothing herein shall limit the board's authority to establish multi-area attendance centers or other student assignment systems for desegregation purposes or otherwise, and to apportion the pupils to the several schools. Furthermore, beginning in school year 1994-95, pursuant to a board plan adopted by October 1, 1993, the board shall offer, commencing on a phased-in basis, the opportunity for families within the school district to apply for enrollment of their children in any attendance center within the school district which does not have selective admission requirements approved by the board. The appropriate geographical area in which such open enrollment may be exercised shall be determined by the board of education. Such children may be admitted to any such attendance center on a space available basis after all children residing within such attendance center's area have been accommodated. If the number of applicants from outside the attendance area exceed the space available, then successful applicants shall be selected by lottery. The board of education's open enrollment plan must include provisions that allow low-income students to have access to transportation needed to exercise school choice. Open enrollment shall be in compliance with the provisions of the Consent Decree and Desegregation Plan cited in Section 34-1.01;

8. To approve programs and policies for providing transportation services to students. Nothing herein shall be construed to permit or empower the State Board of Education to order, mandate, or require busing or other transportation of pupils for the purpose of achieving racial balance in any school;

9. Subject to the limitations in this Article, to establish and approve system-wide curriculum objectives and standards, including graduation standards, which reflect the multi-cultural diversity in the city and are consistent with State law, provided that for all purposes of this Article courses or proficiency in American Sign Language shall be deemed to constitute courses or proficiency in a foreign language; and to employ principals and teachers, appointed as provided in this Article, and fix their compensation. The board shall prepare such reports related to minimal competency testing as may be requested by the State Board of Education and, in addition, shall monitor and approve special education and bilingual education programs and policies within the district to ensure that appropriate services are provided in accordance with applicable State and federal laws to children requiring services and education in those areas;

10. To employ non-teaching personnel or utilize volunteer personnel for: (i) non-teaching duties not requiring instructional judgment or evaluation of pupils, including library duties; and (ii) supervising study halls, long distance teaching reception areas used incident to instructional programs transmitted by electronic media such as computers, video, and audio, detention and discipline areas, and school-sponsored extracurricular activities. The board may further utilize volunteer nonlicensed personnel or employ nonlicensed personnel to assist in the instruction of pupils under the immediate supervision of a teacher holding a valid educator license, directly engaged in teaching subject matter or conducting activities; provided that the teacher shall be continuously aware of the nonlicensed persons' activities and shall be able to control or modify them. The general superintendent shall

determine qualifications of such personnel and shall prescribe rules for determining the duties and activities to be assigned to such personnel;

10.5. To utilize volunteer personnel from a regional School Crisis Assistance Team (S.C.A.T.), created as part of the Safe to Learn Program established pursuant to Section 25 of the Illinois Violence Prevention Act of 1995, to provide assistance to schools in times of violence or other traumatic incidents within a school community by providing crisis intervention services to lessen the effects of emotional trauma on individuals and the community; the School Crisis Assistance Team Steering Committee shall determine the qualifications for volunteers;

11. To provide television studio facilities in not to exceed one school building and to provide programs for educational purposes, provided, however, that the board shall not construct, acquire, operate, or maintain a television transmitter; to grant the use of its studio facilities to a licensed television station located in the school district; and to maintain and operate not to exceed one school radio transmitting station and provide programs for educational purposes;

12. To offer, if deemed appropriate, outdoor education courses, including field trips within the State of Illinois, or adjacent states, and to use school educational funds for the expense of the said outdoor educational programs, whether within the school district or not;

13. During that period of the calendar year not embraced within the regular school term, to provide and conduct courses in subject matters normally embraced in the program of the schools during the regular school term and to give regular school credit for satisfactory completion by the student of such courses as may be approved for credit by the State Board of Education;

14. To insure against any loss or liability of the board, the former School Board Nominating Commission, Local School Councils, the Chicago Schools Academic Accountability Council, or the former Subdistrict Councils or of any member, officer, agent, or employee thereof, resulting from alleged violations of civil rights arising from incidents occurring on or after September 5, 1967 or from the wrongful or negligent act or omission of any such person whether occurring within or without the school premises, provided the officer, agent, or employee was, at the time of the alleged violation of civil rights or wrongful act or omission, acting within the scope of his or her employment or under direction of the board, the former School Board Nominating Commission, the Chicago Schools Academic Accountability Council, Local School Councils, or the former Subdistrict Councils; and to provide for or participate in insurance plans for its officers and employees, including, but not limited to, retirement annuities, medical, surgical and hospitalization benefits in such types and amounts as may be determined by the board; provided, however, that the board shall contract for such insurance only with an insurance company authorized to do business in this State. Such insurance may include provision for employees who rely on treatment by prayer or spiritual means alone for healing, in accordance with the tenets and practice of a recognized religious denomination;

15. To contract with the corporate authorities of any municipality or the county board of any county, as the case may be, to provide for the regulation of traffic in parking areas of property used for school purposes, in such manner as is provided by Section 11-209 of the Illinois Vehicle Code;

16. In this paragraph 16:

"Direct admissions information" means a student's name, home address, birth date, telephone number, email address, and cumulative grade point average.

"Directory information" means a high school student's name, home address, birth date, and telephone number.

"Public institution of higher education" has the meaning given to that term in the Board of Higher Education Act.

(a) To provide, on an equal basis and consistent with the federal Family Educational Rights and Privacy Act of 1974 and the Illinois School Student Records Act, access to a high school campus and student directory information to the official recruiting representatives of the armed forces of Illinois and the United States, to the Illinois Student Assistance Commission, and to public institutions of higher education for the purposes of informing students of the educational and career opportunities available in the military if the board has provided such access to persons or groups whose purpose is to acquaint students with educational or occupational opportunities available to them. The board is not required to give greater notice regarding the right of access to recruiting representatives than is given to other persons and groups. ~~In this paragraph 16, "directory information" means a high school student's name, address, and telephone number.~~

(a-5) To provide, on an equal basis and consistent with the federal Family Educational Rights and Privacy Act of 1974 and the Illinois School Student Records Act, access to student direct admissions information to the Illinois Student Assistance Commission for the purpose of the direct admission program.

(b) If a student or his or her parent or guardian submits a signed, written request to the high school before the end of the student's sophomore year (or if the student is a transfer student, by another time set by the high school) that indicates that the student or his or her parent or guardian does not want the student's directory information to be provided to official recruiting representatives, to the Illinois Student Assistance Commission, and to public institutions of higher education under subparagraph ~~subsection~~ (a) of this paragraph 16 of this Section, the high school may not provide access to the student's directory information to these recruiting representatives, the Illinois Student Assistance Commission, and public institutions of higher education. The high school shall notify its students and their parents or guardians of the provisions of this subparagraph ~~subsection~~ (b).

(b-5) If a student who is 18 years of age or older or the parent or guardian of a student under 18 years of age submits a signed, written or electronic request that indicates that the student or his or her parent or guardian does permit the student's direct admissions information to be provided, the high school shall provide the student's direct admissions information to the Illinois Student Assistance Commission. The Illinois Student Assistance Commission shall provide opt-in language to school districts no later than June 30, 2025. The high school shall notify its students and their parents or guardians of the provisions of this subparagraph (b-5) and, at the time of school registration or at other appropriate times prior to the end of a student's junior year, give its students and their parents or guardians the option for the student information to be shared for the purpose of the direct admission program.

(c) A high school may require official recruiting representatives of the armed forces of Illinois and the United States to pay a fee for copying and mailing a student's directory information in an amount that is not more than the actual costs incurred by the high school.

(d) Information received by an official ~~recruiting representative~~ under this Section may be used only to provide information to students concerning educational and career opportunities ~~available in the military~~ and to assist in designating State Scholars under Section 25 of the Higher Education Student Assistance Act. Information may not be released to a person who is not involved in recruiting students for the armed forces of Illinois or the United States or providing educational opportunity information for the Board of Higher Education, the Illinois Community College Board, the Illinois Student Assistance Commission, or public institutions of higher education.

(e) By July 1, 2026 and each July 1 thereafter, the school district shall make student directory information electronically accessible for official recruiting representatives of the armed forces of Illinois or the United States, to the Illinois Student Assistance Commission, and to public institutions of higher education;

(f) By July 1, 2026 and each July 1 thereafter, the school district shall make student direct admissions information electronically accessible through a secure, centralized data system to the Illinois Student Assistance Commission for the purpose of the direct admission program.

(g) The Board of Higher Education, the Illinois Community College Board, the Illinois Student Assistance Commission, and the State Board of Education may adopt any rules necessary to administer this paragraph 16.

17. (a) To sell or market any computer program developed by an employee of the school district, provided that such employee developed the computer program as a direct result of his or her duties with the school district or through the utilization of school district resources or facilities. The employee who developed the computer program shall be entitled to share in the proceeds of such sale or marketing of the computer program. The distribution of such proceeds between the employee and the school district shall be as agreed upon by the employee and the school district, except that neither the employee nor the school district may receive more than 90% of such proceeds. The negotiation for an employee who is represented by an exclusive bargaining representative may be conducted by such bargaining representative at the employee's request.

(b) For the purpose of this paragraph 17:

(1) "Computer" means an internally programmed, general purpose digital device capable of automatically accepting data, processing data and supplying the results of the operation.

(2) "Computer program" means a series of coded instructions or statements in a form acceptable to a computer, which causes the computer to process data in order to achieve a certain result.

(3) "Proceeds" means profits derived from the marketing or sale of a product after deducting the expenses of developing and marketing such product;

18. To delegate to the general superintendent of schools, by resolution, the authority to approve contracts and expenditures in amounts of \$35,000 or less;

19. Upon the written request of an employee, to withhold from the compensation of that employee any dues, payments, or contributions payable by such employee to any labor organization as defined in the Illinois Educational Labor Relations Act. Under such arrangement, an amount shall be withheld from each regular payroll period which is equal to the pro rata share of the annual dues plus any payments or contributions, and the board shall transmit such withholdings to the specified labor organization within 10 working days from the time of the withholding;

19a. Upon receipt of notice from the comptroller of a municipality with a population of 500,000 or more, a county with a population of 3,000,000 or more, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or a housing authority of a municipality with a population of 500,000 or more that a debt is due and owing the municipality, the county, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or the housing authority by an employee of the Chicago Board of Education, to withhold, from the compensation of that employee, the amount of the debt that is due and owing and pay the amount withheld to the municipality, the county, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or the housing authority; provided, however, that the amount deducted from any one salary or wage payment shall not exceed 25% of the net amount of the payment. Before the Board deducts any amount from any salary or wage of an employee under this paragraph, the municipality, the county, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or the housing authority shall certify that (i) the employee has been afforded an opportunity for a hearing to dispute the debt that is due and owing the municipality, the county, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or the housing authority and (ii) the employee has received notice of a wage deduction order and has been afforded an opportunity for a hearing to object to the order. For purposes of this paragraph, "net amount" means that part of the salary or wage payment remaining after the deduction of any amounts required by law to be deducted and "debt due and owing" means (i) a specified sum of money owed to the municipality, the county, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or the housing authority for services, work, or goods, after the period granted for payment has expired, or (ii) a specified sum of money owed to the municipality, the county, the Cook County Forest Preserve District, the Chicago Park District, the Metropolitan Water Reclamation District, the Chicago Transit Authority, or the housing authority pursuant to a court order or order of an administrative hearing officer after the exhaustion of, or the failure to exhaust, judicial review;

20. The board is encouraged to employ a sufficient number of licensed school counselors to maintain a student/counselor ratio of 250 to 1. Each counselor shall spend at least 75% of his work time in direct contact with students and shall maintain a record of such time;

21. To make available to students vocational and career counseling and to establish 5 special career counseling days for students and parents. On these days representatives of local businesses and industries shall be invited to the school campus and shall inform students of career opportunities available to them in the various businesses and industries. Special consideration shall be given to counseling minority students as to career opportunities available to them in various fields. For the purposes of this paragraph, minority student means a person who is any of the following:

(a) American Indian or Alaska Native (a person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment).

(b) Asian (a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam).

(c) Black or African American (a person having origins in any of the black racial groups of Africa).

(d) Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race).

(e) Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).

Counseling days shall not be in lieu of regular school days;

22. To report to the State Board of Education the annual student dropout rate and number of students who graduate from, transfer from, or otherwise leave bilingual programs;

23. Except as otherwise provided in the Abused and Neglected Child Reporting Act or other applicable State or federal law, to permit school officials to withhold, from any person, information on the whereabouts of any child removed from school premises when the child has been taken into protective custody as a victim of suspected child abuse. School officials shall direct such person to the Department of Children and Family Services or to the local law enforcement agency, if appropriate;

24. To develop a policy, based on the current state of existing school facilities, projected enrollment, and efficient utilization of available resources, for capital improvement of schools and school buildings within the district, addressing in that policy both the relative priority for major repairs, renovations, and additions to school facilities and the advisability or necessity of building new school facilities or closing existing schools to meet current or projected demographic patterns within the district;

25. To make available to the students in every high school attendance center the ability to take all courses necessary to comply with the Board of Higher Education's college entrance criteria effective in 1993;

26. To encourage mid-career changes into the teaching profession, whereby qualified professionals become licensed teachers, by allowing credit for professional employment in related fields when determining point of entry on the teacher pay scale;

27. To provide or contract out training programs for administrative personnel and principals with revised or expanded duties pursuant to this Code in order to ensure they have the knowledge and skills to perform their duties;

28. To establish a fund for the prioritized special needs programs, and to allocate such funds and other lump sum amounts to each attendance center in a manner consistent with the provisions of part 4 of Section 34-2.3. Nothing in this paragraph shall be construed to require any additional appropriations of State funds for this purpose;

29. (Blank);

30. Notwithstanding any other provision of this Act or any other law to the contrary, to contract with third parties for services otherwise performed by employees, including those in a bargaining unit, and to ~~lay off~~ ~~layoff~~ those employees upon 14 ~~days'~~ ~~days~~ written notice to the affected employees. Those contracts may be for a period not to exceed 5 years and may be awarded on a system-wide basis. The board may not operate more than 30 contract schools, provided that the board may operate an additional 5 contract turnaround schools pursuant to item (5.5) of subsection (d) of Section 34-8.3 of this Code, and the governing bodies of contract schools are subject to the Freedom of Information Act and Open Meetings Act;

31. To promulgate rules establishing procedures governing the layoff or reduction in force of employees and the recall of such employees, including, but not limited to, criteria for such layoffs, reductions in force or recall rights of such employees and the weight to be given to any particular criterion. Such criteria shall take into account factors, including, but not limited to, qualifications, certifications, experience, performance ratings or evaluations, and any other factors relating to an employee's job performance;

32. To develop a policy to prevent nepotism in the hiring of personnel or the selection of contractors;

33. (Blank); and

34. To establish a Labor Management Council to the board comprised of representatives of the board, the chief executive officer, and those labor organizations that are the exclusive representatives of employees of the board and to promulgate policies and procedures for the operation of the Council.

The specifications of the powers herein granted are not to be construed as exclusive, but the board shall also exercise all other powers that may be requisite or proper for the maintenance and the development

of a public school system, not inconsistent with the other provisions of this Article or provisions of this Code which apply to all school districts.

In addition to the powers herein granted and authorized to be exercised by the board, it shall be the duty of the board to review or to direct independent reviews of special education expenditures and services. The board shall file a report of such review with the General Assembly on or before May 1, 1990.

(Source: P.A. 102-465, eff. 1-1-22; 102-558, eff. 8-20-21; 102-894, eff. 5-20-22; 103-8, eff. 1-1-24; revised 7-17-24.)

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

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Villa, **House Bill No. 3572** was taken up, read by title a second time. Committee Amendment No. 1 was held in the Committee on Assignments.

The following amendment was offered in the Committee on Criminal Law, adopted and ordered printed:

AMENDMENT NO. 2 TO HOUSE BILL 3572

AMENDMENT NO. 2. Amend House Bill 3572 by replacing everything after the enacting clause with the following:

"Section 1. Reference to Act. This Act may be referred to as the Diversion of Unfit Misdemeanants Act.

Section 5. Purpose. The General Assembly recognizes that there are a substantial number of persons with mental illnesses who are charged with misdemeanors and are found unfit to stand trial under Article 104 of the Code of Criminal Procedure of 1963. Many of these defendants remain in the criminal justice system for periods of time longer than they would have served had they been convicted of the misdemeanor with which they have been charged. These defendants impose a substantial financial burden on county jails, the criminal court system, and State-operated mental health facilities where they are frequently committed under Section 104-17 of the Code of Criminal Procedure of 1963. Additionally, despite extended involvement in the criminal justice system, many of these defendants do not receive the mental health treatment needed to reduce the likelihood that they will commit future offenses and are not successfully linked to ongoing mental health services when their involvement in the criminal justice system ends, including community-based treatment programs. The General Assembly finds that the interests of public safety, the welfare of persons with mental illnesses charged with misdemeanors, and the efficient and effective use of public resources may be served by creating programs which remove these defendants from the criminal justice system and use behavioral health services, case management, and substance use disorder treatment, including, but not limited to, treatment authorized under Articles IV, VII, and VII-A and Section 3-801.5 of Article VIII of the Mental Health and Developmental Disabilities Code.

Section 10. The Code of Criminal Procedure of 1963 is amended by changing Sections 104-11, 104-13, 104-15, and 104-17 and by adding Section 104-32 and Article 104A as follows:

(725 ILCS 5/104-11) (from Ch. 38, par. 104-11)

Sec. 104-11. Raising Issue; Burden; Fitness Motions.)

(a) The issue of the defendant's fitness for trial, to plead, or to be sentenced may be raised by the defense, the State or the Court at any appropriate time before a plea is entered or before, during, or after trial. When a bonafide doubt of the defendant's fitness is raised, other than for eligible defendants charged with one or more misdemeanors subject to Section 104A-1, the court shall order a determination of the issue before proceeding further.

(b) Upon request of the defendant that a qualified expert be appointed to examine him or her to determine prior to trial if a bonafide doubt as to his or her fitness to stand trial may be raised, the court, in its discretion, may order an appropriate examination. However, no order entered pursuant to this subsection

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shall prevent further proceedings in the case. An expert so appointed shall examine the defendant and make a report as provided in Section 104-15. Upon the filing with the court of a verified statement of services rendered, the court shall enter an order on the county board to pay such expert a reasonable fee stated in the order.

(c) When a bonafide doubt of the defendant's fitness has been raised, the burden of proving that the defendant is fit by a preponderance of the evidence and the burden of going forward with the evidence are on the State. However, the court may call its own witnesses and conduct its own inquiry.

(d) Following a finding of unfitness, the court may hear and rule on any pretrial motion or motions if the defendant's presence is not essential to a fair determination of the issues. A motion may be reheard upon a showing that evidence is available which was not available, due to the defendant's unfitness, when the motion was first decided.

(Source: P.A. 81-1217.)

(725 ILCS 5/104-13) (from Ch. 38, par. 104-13)

Sec. 104-13. Fitness examination.

(a) When the issue of fitness involves the defendant's mental condition, the court shall order an examination of the defendant by one or more licensed physicians, clinical psychologists, or psychiatrists chosen by the court. No physician, clinical psychologist or psychiatrist employed by the Department of Human Services shall be ordered to perform, in his official capacity, an examination under this Section.

(a-1) The Administrative Office of the Illinois Courts is encouraged to establish standards and a certification process for court-appointed fitness evaluators designed to increase the availability of qualified evaluators statewide and to increase access, consistency, and fairness within fitness-to-stand-trial proceedings and subsequent placement recommendations.

(b) If the issue of fitness involves the defendant's physical condition, the court shall appoint one or more physicians and in addition, such other experts as it may deem appropriate to examine the defendant and to report to the court regarding the defendant's condition.

(c) An examination ordered under this Section shall be given at the place designated by the person who will conduct the examination, except that if the defendant is being held in custody, the examination shall take place at such location as the court directs. No examinations under this Section shall be ordered to take place at mental health or developmental disabilities facilities operated by the Department of Human Services. If the defendant fails to keep appointments without reasonable cause or if the person conducting the examination reports to the court that diagnosis requires hospitalization or extended observation, the court may order the defendant admitted to an appropriate facility for an examination, other than a screening examination, for not more than 7 days. ~~The court may, upon a showing of good cause, grant an additional 7 days to complete the examination.~~

~~(d) Pretrial Release on pretrial release or on recognizance shall not be revoked and an application therefor shall not be denied on the grounds that an examination has been ordered.~~

(e) Upon request by the defense and if the defendant is indigent, the court may appoint, in addition to the expert or experts chosen pursuant to subsection (a) of this Section, a qualified expert selected by the defendant to examine him and to make a report as provided in Section 104-15. Upon the filing with the court of a verified statement of services rendered, the court shall enter an order on the county board to pay such expert a reasonable fee stated in the order.

(Source: P.A. 101-652, eff. 1-1-23.)

(725 ILCS 5/104-15) (from Ch. 38, par. 104-15)

Sec. 104-15. Report.

(a) The person or persons conducting an examination of the defendant, pursuant to paragraph (a) or (b) of Section 104-13 shall submit a written report to the court, the State, and the defense within 30 days of the date of the order. The report shall include:

(1) A diagnosis and an explanation as to how it was reached and the facts upon which it is based;

(2) A description of the defendant's mental or physical disability, if any; its severity; and an opinion as to whether and to what extent it impairs the defendant's ability to understand the nature and purpose of the proceedings against him or to assist in his defense, or both.

(b) If the report indicates that the defendant is not fit to stand trial or to plead because of a disability, the report shall include an opinion as to the likelihood of the defendant attaining fitness within the statutory ~~a~~ period of time from the date of the finding of unfitness if provided with a course of treatment. For a defendant charged with a felony, the period of time shall be one year. For a defendant charged with a

misdeemeanor, the period of time shall be no longer than the maximum term of imprisonment for the most serious offense. The period of commitment shall not exceed the maximum length of time that the defendant would have been required to serve, less credit for good behavior as provided in Section 5-4-1 of the Unified Code of Corrections. Defendants charged with petty offenses or infraction of a municipal ordinance are not eligible for fitness restoration services. If the person or persons preparing the initial fitness report are unable to form such an opinion, the report shall state the reasons therefor. The report shall ~~may~~ include a general description of the type of treatment needed and of the least physically restrictive form of treatment therapeutically appropriate. If inpatient treatment is recommended, the report must articulate the evaluator's assessment of risk, protective factors, and treatment needs as related to the defendant's mental disorder. Risk shall not be determined solely by the nature of the defendant's criminal charges.

(c) The report shall indicate what information, if any, contained therein may be harmful to the mental condition of the defendant if made known to him.

(d) In addition to the report, a person retained or appointed by the State or the defense to conduct an examination shall, upon written request, make his or her notes, other evaluations reviewed or relied upon by the testifying witness, and any videotaped interviews available to another examiner of the defendant. All forensic interviews conducted by a person retained or appointed by the State or the defense shall be videotaped unless doing so would be impractical. In the event that the interview is not videotaped, the examiner may still testify as to the person's fitness and the court may only consider the lack of compliance in according the weight and not the admissibility of the expert testimony. An examiner may use these materials as part of his or her diagnosis and explanation but shall not otherwise disclose the contents, including at a hearing before the court, except as otherwise provided in Section 104-14 of this Code.

(Source: P.A. 100-424, eff. 1-1-18.)

(725 ILCS 5/104-17) (from Ch. 38, par. 104-17)

Sec. 104-17. Commitment for treatment; treatment plan.

(a) If the defendant is eligible to be or has been released on pretrial release ~~or on his own recognizance~~, the court shall select the least physically restrictive form of treatment therapeutically appropriate and consistent with the treatment plan. The placement may be ordered either on an inpatient or an outpatient basis. Placement shall be on an outpatient basis unless the court determines that:

(1) treatment on an outpatient basis is reasonably expected to inflict serious physical harm upon the defendant or another. No defendant may be ordered to inpatient restoration unless at least one licensed physician, clinical psychologist, or psychiatrist who has examined the defendant testifies in person at the hearing. The defendant may waive the requirement of the testimony subject to the approval of the court; or

(2) treatment that will restore the defendant to fitness within a reasonable period of time is not available on an outpatient basis.

(b) If the defendant's disability is mental, the court may order him placed for secure treatment in the custody of the Department of Human Services, or the court may order him placed in the custody of any other appropriate public or private mental health facility or treatment program which has agreed to provide treatment to the defendant. If the most serious charge faced by the defendant is a misdemeanor, the court shall order outpatient treatment, unless the court finds ~~good cause~~ on the record that the defendant is reasonably expected to inflict serious physical harm on the defendant or another due to mental illness. No defendant may be ordered to inpatient restoration unless at least one licensed physician, clinical psychologist, or psychiatrist who has examined the defendant testifies in person at the hearing. The defendant may waive the requirement of the testimony subject to the approval of the court to order inpatient treatment. If the court orders the defendant to inpatient treatment in the custody of the Department of Human Services, the Department shall evaluate the defendant to determine the most appropriate secure facility to receive the defendant and, within 20 days of the transmittal by the clerk of the circuit court of the court's placement order, notify the court of the designated facility to receive the defendant. The Department shall admit the defendant to a secure facility within 60 days of the transmittal of the court's placement order, unless the Department can demonstrate good faith efforts at placement and a lack of bed and placement availability. If placement cannot be made within 60 days of the transmittal of the court's placement order and the Department has demonstrated good faith efforts at placement and a lack of bed and placement availability, the Department shall provide an update to the ordering court every 30 days until the defendant is placed. Once bed and placement availability is determined, the Department shall notify the sheriff who shall promptly transport the defendant to the designated facility. If the defendant is placed in the custody of the Department of Human Services, the defendant shall be placed in a secure setting. During the period of

time required to determine bed and placement availability at the designated facility, the defendant shall remain in jail. If during the course of evaluating the defendant for placement, the Department of Human Services determines that the defendant is currently fit to stand trial, it shall immediately notify the court and shall submit a written report within 7 days. In that circumstance the placement shall be held pending a court hearing on the Department's report. Otherwise, upon completion of the placement process, including identifying bed and placement availability, the sheriff shall be notified and shall transport the defendant to the designated facility. If, within 60 days of the transmittal by the clerk of the circuit court of the court's placement order, the Department fails to provide the sheriff with notice of bed and placement availability at the designated facility, the sheriff shall contact the Department to inquire about when a placement will become available at the designated facility as well as bed and placement availability at other secure facilities. The Department shall respond to the sheriff within 2 business days of the notice and inquiry by the sheriff seeking the transfer and the Department shall provide the sheriff with the status of the evaluation, information on bed and placement availability, and an estimated date of admission for the defendant and any changes to that estimated date of admission. If the Department notifies the sheriff during the 2 business day period of a facility operated by the Department with placement availability, the sheriff shall promptly transport the defendant to that facility. The placement may be ordered either on an inpatient or an outpatient basis.

(c) If the defendant's disability is physical, the court may order him placed under the supervision of the Department of Human Services which shall place and maintain the defendant in a suitable treatment facility or program, or the court may order him placed in an appropriate public or private facility or treatment program which has agreed to provide treatment to the defendant. The placement may be ordered either on an inpatient or an outpatient basis.

(d) The clerk of the circuit court shall within 5 days of the entry of the order transmit to the Department, agency or institution, if any, to which the defendant is remanded for treatment, the following:

- (1) a certified copy of the order to undergo treatment. Accompanying the certified copy of the order to undergo treatment shall be the complete copy of any report prepared under Section 104-15 of this Code or other report prepared by a forensic examiner for the court;
- (2) the county and municipality in which the offense was committed;
- (3) the county and municipality in which the arrest took place;
- (4) a copy of the arrest report, criminal charges, arrest record; and
- (5) all additional matters which the Court directs the clerk to transmit.

(e) Within 30 days of admission to the designated facility, the person supervising the defendant's treatment shall file with the court, the State, and the defense a report assessing the facility's or program's capacity to provide appropriate treatment for the defendant and indicating his opinion as to the probability of the defendant's attaining fitness within a period of time from the date of the finding of unfitness. For a defendant charged with a felony, the period of time shall be one year. For a defendant charged with a misdemeanor, the period of time shall be no longer than the sentence if convicted of the most serious offense, less credit for good behavior as provided in Section 5-4-1 of the Unified Code of Corrections. If the report indicates that there is a substantial probability that the defendant will attain fitness within the time period, the treatment supervisor shall also file a treatment plan which shall include:

- (1) A diagnosis of the defendant's disability;
- (2) A description of treatment goals with respect to rendering the defendant fit, a specification of the proposed treatment modalities, and an estimated timetable for attainment of the goals;
- (3) An identification of the person in charge of supervising the defendant's treatment.

(Source: P.A. 101-652, eff. 1-1-23; 102-1118, eff. 1-18-23.)

(725 ILCS 5/104-32 new)

Sec. 104-32. Fitness to Stand Trial Task Force.

(a) There is created the Fitness to Stand Trial Task Force hereinafter referred to as the Task Force. The Task Force shall conduct a thorough review of the statutory and regulatory provisions governing the procedures by which individuals facing criminal charges may be unfit to stand trial. This review includes, but is not limited to, the determination of fitness, the housing and custodial status of persons undergoing fitness restoration, the rights of individuals found unfit, and the obligations of the Department of Human Services.

(b) The Task Force shall consist of 15 members, appointed as follows:

- (1) a member of the House of Representatives, appointed by the Speaker of the House, who shall serve as co-chair of the Task Force;

(2) a member of the House of Representatives, appointed by the Minority Leader of the House;
(3) a member of the Senate appointed by the President of the Senate, who shall serve as co-chair of the Task Force;

(4) a member of the Senate, appointed by the Minority Leader of the Senate;

(5) 2 members appointed by the Illinois Supreme Court;

(6) the Secretary of Human Services or the Secretary's designee;

(7) a member nominated by a statewide organization that represents State's Attorneys and appointed by the Governor;

(8) a member nominated by a statewide organization that represents public defenders and appointed by the Governor;

(9) a member nominated by a statewide organization that represents sheriffs and appointed by the Governor;

(10) a member representing the federally mandated Protection and Advocacy System for people with mental illness in the State of Illinois, appointed by the Governor;

(11) a member representing an organization or agency providing community-based mental health services, appointed by the Governor;

(12) a member representing a nonprofit organization dedicated to the promotion of mental health, well-being, and illness prevention, appointed by the Governor;

(13) a member who is a licensed clinical psychologist with specialized forensic training and experience conducting court-ordered fitness evaluations in Illinois, appointed by the Governor; and

(14) a member who is a licensed clinical psychologist with specialized forensic training and experience providing fitness restoration services in Illinois, appointed by the Governor.

(c) The Department shall provide administrative and technical support for the Task Force and is responsible for ensuring that the requirements of the Task Force are met.

(d) The Task Force shall hold its first meeting no later than October 1, 2025.

(e) The Task Force shall submit a report containing its findings and any recommendations to the Supreme Court and the General Assembly on or before November 1, 2026.

(f) The Task Force may at any time identify legislative proposals in support of its mission prior to the issuance of its final report.

(g) The Task Force shall be dissolved following the submission of its report to the Supreme Court and the General Assembly.

(725 ILCS 5/Art. 104A heading new)

ARTICLE 104A. DIVERSION OF UNFIT MISDEMEANANTS

(725 ILCS 5/104A-1 new)

Sec. 104A-1. Eligibility. A defendant charged with one or more misdemeanors and for whom a court has determined under Section 104-11 of this Code that a bona fide doubt of the defendant's fitness has been raised may be admitted into an unfit misdemeanor diversion program only upon the approval of the court.

(725 ILCS 5/104A-2 new)

Sec. 104A-2. Rulemaking. The Illinois Supreme Court or any circuit court of this State may adopt rules establishing unfit misdemeanor diversion programs consistent with this Article.

(725 ILCS 5/104A-3 new)

Sec. 104A-3. Procedure. The court shall require an eligibility screening and an assessment of the defendant to determine whether the defendant may be able to receive mental health services under the Mental Health and Developmental Disabilities Code which shall reasonably assure his or her safety and that of the public and his or her continued participation in treatment. If, following this screening, the State and the defendant agree to the diversion and the court determines that the defendant is appropriate for diversion, the criminal charges may be dismissed. If the parties do not agree or the court does not approve, the court shall order a fitness examination under Section 104-13 of this Code and the matter shall be governed by any other relevant provisions of Article 104.

(725 ILCS 5/104A-4 new)

Sec. 104A-4. Mental health and substance use treatment. The misdemeanor diversion program may maintain or collaborate with mental health and substance use treatment providers necessary to provide a continuum of treatment options commensurate with the needs of the defendant and available resources. Treatment programs shall comply with all relevant statutes and rules. The Department of Human Services shall provide care to persons determined to be subject to involuntary admission on an inpatient basis as

defined in Section 1-119 of the Mental Health and Developmental Disabilities Code or may make arrangements with any other appropriate inpatient mental health facility to provide those services.

Section 99. Effective date. This Section and Section 104-32 of the Code of Criminal Procedure of 1963 take effect upon becoming law."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Fine, **House Bill No. 3645** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Glowiak Hilton, **House Bill No. 3671** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 3677** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Insurance, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 3677

AMENDMENT NO. 1. Amend House Bill 3677 on page 2, by deleting lines 1 through 19; and on page 2, by deleting lines 25 and 26; and by deleting line 17 on page 4 through line 7 on page 5; and on page 5, by replacing lines 8 through 13 with the following:

"Section 25. Enforcement. A violation of any of the provisions of this Act is an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act. All remedies, penalties, and authority granted by that Act shall be available for the enforcement of this Act."; and

on page 32, by replacing lines 2 through 6 with the following:

"(815 ILCS 505/2HHHH new)

Sec. 2HHHH. Violations of the Complex Rehabilitation Technology Act. A person who violates the Complex Rehabilitation Technology Act commits an unlawful practice within the meaning of this Act."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Villanueva, **House Bill No. 3710** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 3718** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Health and Human Services, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 3718

AMENDMENT NO. 1. Amend House Bill 3718 by replacing everything after the enacting clause with the following:

"Section 5. The Mental Health and Developmental Disabilities Code is amended by changing Section 3-210 as follows:

(405 ILCS 5/3-210) (from Ch. 91 1/2, par. 3-210)

Sec. 3-210. Employee as perpetrator of abuse. When, based upon credible evidence, an initial investigation of a reported allegation of material obstruction of an investigation or of abuse, neglect, or

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financial exploitation of a recipient of services indicates that it is reasonable to believe, ~~based upon credible evidence,~~ that an employee at ~~of~~ a mental health or developmental disability facility is the perpetrator of physical abuse, sexual abuse, non-de minimis financial exploitation (such as financial exploitation totaling a cumulative value equal to or greater than \$20), ~~egregious neglect, or material obstruction of an investigation, the abuse,~~ that employee shall immediately be barred from any further contact with recipients of services of the facility. An employee barred from contact with recipients of services shall remain barred:

(1) pending the outcome of any further investigation, prosecution, or disciplinary action against the employee; or

(2) until the Department of Human Services Office of Inspector General independently determines that the physical abuse, sexual abuse, non-de minimis financial exploitation, egregious neglect, or material obstruction of an investigation allegation or allegations against the employee will be unsubstantiated or unfounded in the Office of Inspector General's final investigative report.

When, based upon credible evidence, an initial investigation of a reported allegation of abuse or neglect of a recipient of services indicates that it is reasonable to believe that an employee at a mental health or developmental disability facility is the perpetrator of, at most, neglect, de minimis financial exploitation (such as financial exploitation totaling a cumulative value of less than \$20), or mental abuse, the Department shall determine what appropriate steps should be taken as to the employee while the investigation of the Department of Human Services Office of Inspector General is pending. These steps by the Department may include, but not be limited to: training, re-assignment away from and a bar from contact with the alleged victim, being barred from any further contact with recipients of services of the facility, or pursuing discipline for known conduct. If further investigation reveals that the conduct rose to the level of physical abuse, sexual abuse, non-de minimis financial exploitation, egregious neglect, or material obstruction of an investigation, then the employee shall be barred from contact with recipients of services and shall remain barred, subject to the conditions detailed in this paragraph.

For the purposes of this Section, "credible evidence" is any evidence that relates to the allegation or incident and that is considered believable and reliable.

Nothing in this Section is intended to include an employee of a hospital licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act or a hospital affiliate. (Source: P.A. 102-501, eff. 1-1-22)."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Edly-Allen, **House Bill No. 3761** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Ventura, **House Bill No. 3796** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Morrison, **House Bill No. 3800** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Insurance, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 3800

AMENDMENT NO. 1 . Amend House Bill 3800 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 121-2.08, 155.04, 174, 194, 368d, 370c.1, and 1563 and by renumbering and changing Section 356z.71 (as amended by Public Act 103-700) as follows:

(215 ILCS 5/121-2.08) (from Ch. 73, par. 733-2.08)

Sec. 121-2.08. Transactions in this State involving contracts of insurance independently procured directly from an unauthorized insurer by industrial insureds.

(a) As used in this Section:

"Exempt commercial purchaser" means exempt commercial purchaser as the term is defined in subsection (1) of Section 445 of this Code.

"Home state" means home state as the term is defined in subsection (1) of Section 445 of this Code.

"Industrial insured" means an insured:

(i) that procures the insurance of any risk or risks of the kinds specified in Classes 2 and 3 of Section 4 of this Code by use of the services of a full-time employee who is a qualified risk manager or the services of a regularly and continuously retained consultant who is a qualified risk manager;

(ii) that procures the insurance ~~directly from an unauthorized insurer~~ without the services of an intermediary insurance producer; and

(iii) that is an exempt commercial purchaser whose home state is Illinois.

"Insurance producer" means insurance producer as the term is defined in Section 500-10 of this Code.

"Qualified risk manager" means qualified risk manager as the term is defined in subsection (1) of Section 445 of this Code.

"Safety-Net Hospital" means an Illinois hospital that qualifies as a Safety-Net Hospital under Section 5-5e.1 of the Illinois Public Aid Code.

"Unauthorized insurer" means unauthorized insurer as the term is defined in subsection (1) of Section 445 of this Code.

(b) For contracts of insurance procured directly from an unauthorized insurer effective January 1, 2015 or later, within 90 days after the effective date of each contract of insurance issued under this Section, the insured shall file a report with the Director by submitting the report to the Surplus Line Association of Illinois in writing or in a computer readable format and provide information as designated by the Surplus Line Association of Illinois. The information in the report shall be substantially similar to that required for surplus line submissions as described in subsection (5) of Section 445 of this Code. Where applicable, the report shall satisfy, with respect to the subject insurance, the reporting requirement of Section 12 of the Fire Investigation Act.

(c) For contracts of insurance procured directly from an unauthorized insurer effective January 1, 2015 through December 31, 2017, within 30 days after filing the report, the insured shall pay to the Director for the use and benefit of the State a sum equal to the gross premium of the contract of insurance multiplied by the surplus line tax rate, as described in paragraph (3) of subsection (a) of Section 445 of this Code, and shall pay the fire marshal tax that would otherwise be due annually in March for insurance subject to tax under Section 12 of the Fire Investigation Act. For contracts of insurance procured directly from an unauthorized insurer effective January 1, 2018 or later, within 30 days after filing the report, the insured shall pay to the Director for the use and benefit of the State a sum equal to 0.5% of the gross premium of the contract of insurance, and shall pay the fire marshal tax that would otherwise be due annually in March for insurance subject to tax under Section 12 of the Fire Investigation Act. For contracts of insurance procured directly from an unauthorized insurer effective January 1, 2015 or later, within 30 days after filing the report, the insured shall pay to the Surplus Line Association of Illinois a countersigning fee that shall be assessed at the same rate charged to members pursuant to subsection (4) of Section 445.1 of this Code.

(d) For contracts of insurance procured directly from an unauthorized insurer effective January 1, 2015 or later, the insured shall withhold the amount of the taxes and countersignature fee from the amount of premium charged by and otherwise payable to the insurer for the insurance. If the insured fails to withhold the tax and countersignature fee from the premium, then the insured shall be liable for the amounts thereof and shall pay the amounts as prescribed in subsection (c) of this Section.

(e) Contracts of insurance with an industrial insured that qualifies as a Safety-Net Hospital are not subject to subsections (b) through (d) of this Section.

(Source: P.A. 100-535, eff. 9-22-17; 100-1118, eff. 11-27-18.)

(215 ILCS 5/155.04) (from Ch. 73, par. 767.4)

Sec. 155.04. Standards for companies and officials.

(1) The Director shall not approve any declaration of organization or Articles of Incorporation or issue a Certificate of Authority to any company until he has found that:

(a) the company has submitted a sound plan of operation; ~~and~~

(b) ~~the general character and experience of the incorporators, directors, and proposed officers is such as to assure reasonable promise of a successful operation, based on the fact that such persons are of known good character and that there is no good reason to believe that they are affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions or other insurance of business relations with any person or persons known to have been involved in the improper manipulation of assets, accounts or reinsurance;~~

(c) the general experience of the incorporators, directors, and proposed officers is enough to ensure the reasonable promise of a successful operation; and

(d) no financial concerns related to the company, its ownership, its associated group, or its affiliates have been identified that raise the possibility that the company will have solvency concerns or problems generating the necessary levels of capital and surplus.

The Director may require, in substantially the same form, the information required under Section 131.5 of this Code.

(2) All companies licensed to do business in this state must notify the Director within 30 days of the appointment or election of any new officers or directors.

(3) Except in cases where the Director deems that any officer or director meets the standards set forth in this section, he shall, after notice and hearing afforded to the officer or director, and after a finding that the officer or director is incompetent or untrustworthy or of known bad character, order the removal of the person. If a company does not comply with a removal order within 30 days, the Director shall suspend that company's Certificate of Authority until such time as the order is complied with.

(4) It shall be unlawful for a company to borrow money or receive a loan or advance from anyone convicted of a felony, anyone who is untrustworthy or of known bad character or anyone convicted of a criminal offense involving the conversion or misappropriation of fiduciary funds or insurance accounts, theft, deceit, fraud, misrepresentation or corruption.

(Source: P.A. 89-97, eff. 7-7-95.)

(215 ILCS 5/174) (from Ch. 73, par. 786)

Sec. 174. Kinds of agreements requiring approval.

(1) The following kinds of reinsurance agreements shall not be entered into by any domestic company unless such agreements are approved in writing by the Director:

(a) Agreements of reinsurance of any such company transacting the kind or kinds of business enumerated in Class 1 of Section 4, or as a Fraternal Benefit Society under Article XVII, a Mutual Benefit Association under Article XVIII, a Burial Society under Article XIX or an Assessment Accident and Assessment Accident and Health Company under Article XXI, cedes previously issued and outstanding risks to any company, or cedes any risks to a company not authorized to transact business in this State, or assumes any outstanding risks on which the aggregate reserves and claim liabilities exceed 20% 20 percent of the aggregate reserves and claim liabilities of the assuming company, as reported in the preceding annual statement, for the business of either life or accident and health insurance.

(b) Any agreement or agreements of reinsurance whereby any company transacting the kind or kinds of business enumerated in either Class 2 or Class 3 of Section 4 cedes to any company or companies at one time, or during a period of six consecutive months more than 20% twenty per centum of the total amount of its net previously retained unearned premium reserve liability. The Director has the right to request additional filing review and approval of all contracts that contribute to the statutory threshold trigger. As used in this Section, "net unearned premium reserve liability" means a liability associated with existing or in-force business that is not ceded to any reinsurer before the effective date of the proposed reinsurance contract.

(c) (Blank).

(2) Requests for approval shall be filed at least 30 working days prior to the stated effective date of the agreement. An agreement which is not disapproved by the Director within 30 working thirty days after its complete submission shall be deemed approved.

(Source: P.A. 98-969, eff. 1-1-15.)

(215 ILCS 5/194) (from Ch. 73, par. 806)

Sec. 194. Rights and liabilities of creditors fixed upon liquidation.

(a) The rights and liabilities of the company and of its creditors, policyholders, stockholders or members and all other persons interested in its assets, except persons entitled to file contingent claims, shall be fixed as of the date of the entry of the Order directing liquidation or rehabilitation unless otherwise provided by Order of the Court. The rights of claimants entitled to file contingent claims or to have their claims estimated shall be determined as provided in Section 209.

(b) The Director may, within 2 years after the entry of an order for rehabilitation or liquidation or within such further time as applicable law permits, institute an action, claim, suit, or proceeding upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of filing of the complaint upon which the order is entered.

(c) The time between the filing of a complaint for conservation, rehabilitation, or liquidation against the company and the denial of the complaint shall not be considered to be a part of the time within which

any action may be commenced against the company. Any action against the company that might have been commenced when the complaint was filed may be commenced for at least 180 days after the complaint is denied.

(d) Notwithstanding subsection (a) of this Section, policies of life, disability income, long-term care, health insurance or annuities covered by a guaranty association, or portions of such policies covered by one or more guaranty associations under applicable law shall continue in force, subject to the terms of the policy (including any terms restructured pursuant to a court-approved rehabilitation plan) to the extent necessary to permit the guaranty associations to discharge their statutory obligations. Policies of life, disability income, long-term care, health insurance or annuities, or portions of such policies not covered by one or more guaranty associations shall terminate as provided under subsection (a) of this Section and paragraph (6) of Section 193 of this Article, except to the extent the Director proposes and the court approves the use of property of the liquidation estate for the purpose of either (1) continuing the contracts or coverage by transferring them to an assuming reinsurer, or (2) distributing dividends under Section 210 of this Article. Claims incurred during the extension of coverage provided for in this Article shall be classified at priority level (d) under paragraph (1) of Section 205 of this Article.

(Source: P.A. 88-297; 89-206, eff. 7-21-95.)

(215 ILCS 5/356z.73)

Sec. 356z.73 ~~356z.74~~. Insurance coverage for dependent parents.

(a) A group or individual policy of accident and health insurance issued, amended, delivered, or renewed on or after January 1, 2026 that provides dependent coverage shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent meets the definition of a qualifying relative under 26 U.S.C. 152(d) and lives or resides within the accident and health insurance policy's service area.

(b) This Section does not apply to specialized health care service plans, Medicare supplement insurance, hospital-only policies, accident-only policies, or specified disease insurance policies that reimburse for hospital, medical, or surgical expenses.

(Source: P.A. 103-700, eff. 1-1-25; revised 12-3-24.)

(215 ILCS 5/368d)

Sec. 368d. Recoupments.

(a) A health care professional or health care provider shall be provided a remittance advice, which must include an explanation of a recoupment or offset taken by an insurer, health maintenance organization, independent practice association, or physician hospital organization, if any. The recoupment explanation shall, at a minimum, include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. In addition, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide with the remittance advice, or with any demand for recoupment or offset, a telephone number or mailing address to initiate an appeal of the recoupment or offset together with the deadline for initiating an appeal. Such information shall be prominently displayed on the remittance advice or written document containing the demand for recoupment or offset. Any appeal of a recoupment or offset by a health care professional or health care provider must be made within 60 days after receipt of the remittance advice.

(b) It is not a recoupment when a health care professional or health care provider is paid an amount prospectively or concurrently under a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization that requires a retrospective reconciliation based upon specific conditions outlined in the contract.

(c) No recoupment or offset may be requested or withheld from future payments 12 months or more after the original payment is made, except in cases in which:

(1) a court, government administrative agency, other tribunal, or independent third-party arbitrator makes or has made a formal finding of fraud or material misrepresentation;

(2) an insurer is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act;

(3) the provider has already been paid in full by any other payer, third party, or workers' compensation insurer; ~~or~~

(4) an insurer contracted with the Department of Healthcare and Family Services is required by the Department of Healthcare and Family Services to recoup or offset payments due to a federal Medicaid requirement; or

(5) the insurer has requested the recoupment or offset within 12 months, but the insurer and the health care professional or health care provider mutually agree to a different time limit for the recoupment or offset to be withheld from future payments.

No contract between an insurer and a health care professional or health care provider may provide for recoupments in violation of this Section. Nothing in this Section shall be construed to preclude insurers, health maintenance organizations, independent practice associations, or physician hospital organizations from resolving coordination of benefits between or among each other, including, but not limited to, resolution of workers' compensation and third-party liability cases, without recouping payment from the provider beyond the 12-month ~~18-month~~ time limit provided in this subsection (c).

(Source: P.A. 102-632, eff. 1-1-22.)

(215 ILCS 5/370c.1)

Sec. 370c.1. Mental, emotional, nervous, or substance use disorder or condition parity.

(a) On and after July 23, 2021 (the effective date of Public Act 102-135), every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall ensure prior to policy issuance that:

(1) the financial requirements applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost-sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits; and

(2) the treatment limitations applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.

(b) The following provisions shall apply concerning aggregate lifetime limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after September 9, 2015 (the effective date of Public Act 99-480) that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an aggregate lifetime limit on substantially all hospital and medical benefits, then the policy may not impose any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an aggregate lifetime limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable lifetime limit"), then the policy shall either:

(i) apply the applicable lifetime limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable lifetime limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (b) of this Section and that includes no or different aggregate lifetime limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (b) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(c) The following provisions shall apply concerning annual limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed

in this State on or after September 9, 2015 (the effective date of Public Act 99-480) that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an annual limit on substantially all hospital and medical benefits, then the policy may not impose any annual limits on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an annual limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable annual limit"), then the policy shall either:

(i) apply the applicable annual limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any annual limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable annual limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (c) of this Section and that includes no or different annual limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (c) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(d) With respect to mental, emotional, nervous, or substance use disorders or conditions, an insurer shall use policies and procedures for the election and placement of mental, emotional, nervous, or substance use disorder or condition treatment drugs on their formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of drugs for medical or surgical conditions and shall follow the expedited coverage determination requirements for substance abuse treatment drugs set forth in Section 45.2 of the Managed Care Reform and Patient Rights Act.

(e) This Section shall be interpreted in a manner consistent with all applicable federal parity regulations including, but not limited to, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans.

(f) The provisions of subsections (b) and (c) of this Section shall not be interpreted to allow the use of lifetime or annual limits otherwise prohibited by State or federal law.

(g) As used in this Section:

"Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket maximums, but does not include an aggregate lifetime limit or an annual limit subject to subsections (b) and (c).

"Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Treatment limitation" includes limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. "Treatment limitation" includes both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of treatment. A permanent exclusion of all benefits for a particular condition or disorder shall not be considered a treatment limitation. "Nonquantitative treatment" means those limitations as described under federal regulations (26 CFR 54.9812-1). "Nonquantitative treatment limitations" include, but are not limited to, those limitations described under federal regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(h) The Department of Insurance shall implement the following education initiatives:

(1) By January 1, 2016, the Department shall develop a plan for a Consumer Education Campaign on parity. The Consumer Education Campaign shall focus its efforts throughout the State and include trainings in the northern, southern, and central regions of the State, as defined by the Department, as well as each of the 5 managed care regions of the State as identified by the Department of Healthcare and Family Services. Under this Consumer Education Campaign, the Department shall: (1) by January 1, 2017, provide at least one live training in each region on parity for consumers and providers and one webinar training to be posted on the Department website and (2) establish a consumer hotline to assist consumers in navigating the parity process by March 1, 2017. By January 1, 2018 the Department shall issue a report to the General Assembly on the success of the Consumer Education Campaign, which shall indicate whether additional training is necessary or would be recommended.

~~(2) (Blank). The Department, in coordination with the Department of Human Services and the Department of Healthcare and Family Services, shall convene a working group of health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups for the purpose of discussing issues related to the treatment and coverage of mental, emotional, nervous, or substance use disorders or conditions and compliance with parity obligations under State and federal law. Compliance shall be measured, tracked, and shared during the meetings of the working group. The working group shall meet once before January 1, 2016 and shall meet semiannually thereafter. The Department shall issue an annual report to the General Assembly that includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the working group meetings, details on the issues and topics covered, and any legislative recommendations developed by the working group.~~

(3) Not later than January 1 of each year, the Department, in conjunction with the Department of Healthcare and Family Services, shall issue a joint report to the General Assembly and provide an educational presentation to the General Assembly. The report and presentation shall:

(A) Cover the methodology the Departments use to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j).

(B) Cover the methodology the Departments use to check for compliance with this Section and Sections 356z.23 and 370c of this Code.

(C) Identify market conduct examinations or, in the case of the Department of Healthcare and Family Services, audits conducted or completed during the preceding 12-month period regarding compliance with parity in mental, emotional, nervous, and substance use disorder or condition benefits under State and federal laws and summarize the results of such market conduct examinations and audits. This shall include:

- (i) the number of market conduct examinations and audits initiated and completed;
- (ii) the benefit classifications examined by each market conduct examination and audit;
- (iii) the subject matter of each market conduct examination and audit, including quantitative and nonquantitative treatment limitations; and
- (iv) a summary of the basis for the final decision rendered in each market conduct examination and audit.

Individually identifiable information shall be excluded from the reports consistent with federal privacy protections.

(D) Detail any educational or corrective actions the Departments have taken to ensure compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), this Section, and Sections 356z.23 and 370c of this Code.

(E) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the Departments find appropriate, posting the report on the Departments' websites.

(i) The Parity Advancement Fund is created as a special fund in the State treasury. Moneys from fines and penalties collected from insurers for violations of this Section shall be deposited into the Fund. Moneys

deposited into the Fund for appropriation by the General Assembly to the Department shall be used for the purpose of providing financial support of the Consumer Education Campaign, parity compliance advocacy, and other initiatives that support parity implementation and enforcement on behalf of consumers.

(j) (Blank).

(j-5) The Department of Insurance shall collect the following information:

(1) The number of employment disability insurance plans offered in this State, including, but not limited to:

- (A) individual short-term policies;
- (B) individual long-term policies;
- (C) group short-term policies; and
- (D) group long-term policies.

(2) The number of policies referenced in paragraph (1) of this subsection that limit mental health and substance use disorder benefits.

(3) The average defined benefit period for the policies referenced in paragraph (1) of this subsection, both for those policies that limit and those policies that have no limitation on mental health and substance use disorder benefits.

(4) Whether the policies referenced in paragraph (1) of this subsection are purchased on a voluntary or non-voluntary basis.

(5) The identities of the individuals, entities, or a combination of the 2 that assume the cost associated with covering the policies referenced in paragraph (1) of this subsection.

(6) The average defined benefit period for plans that cover physical disability and mental health and substance abuse without limitation, including, but not limited to:

- (A) individual short-term policies;
- (B) individual long-term policies;
- (C) group short-term policies; and
- (D) group long-term policies.

(7) The average premiums for disability income insurance issued in this State for:

- (A) individual short-term policies that limit mental health and substance use disorder benefits;
- (B) individual long-term policies that limit mental health and substance use disorder benefits;
- (C) group short-term policies that limit mental health and substance use disorder benefits;
- (D) group long-term policies that limit mental health and substance use disorder benefits;
- (E) individual short-term policies that include mental health and substance use disorder benefits without limitation;
- (F) individual long-term policies that include mental health and substance use disorder benefits without limitation;
- (G) group short-term policies that include mental health and substance use disorder benefits without limitation; and
- (H) group long-term policies that include mental health and substance use disorder benefits without limitation.

The Department shall present its findings regarding information collected under this subsection (j-5) to the General Assembly no later than April 30, 2024. Information regarding a specific insurance provider's contributions to the Department's report shall be exempt from disclosure under paragraph (t) of subsection (1) of Section 7 of the Freedom of Information Act. The aggregated information gathered by the Department shall not be exempt from disclosure under paragraph (t) of subsection (1) of Section 7 of the Freedom of Information Act.

(k) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall submit an annual report, the format and definitions for which will be determined by the Department and the Department of Healthcare and Family Services and posted on their respective websites, starting on September 1, 2023 and annually thereafter, that contains the following information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug

benefits in the case of accident and health insurance or qualified health plans, or inpatient, outpatient, emergency care, and prescription drug benefits in the case of medical assistance:

(1) A summary of the plan's pharmacy management processes for mental, emotional, nervous, or substance use disorder or condition benefits compared to those for other medical benefits.

(2) A summary of the internal processes of review for experimental benefits and unproven technology for mental, emotional, nervous, or substance use disorder or condition benefits and those for other medical benefits.

(3) A summary of how the plan's policies and procedures for utilization management for mental, emotional, nervous, or substance use disorder or condition benefits compare to those for other medical benefits.

(4) A description of the process used to develop or select the medical necessity criteria for mental, emotional, nervous, or substance use disorder or condition benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(5) Identification of all nonquantitative treatment limitations that are applied to both mental, emotional, nervous, or substance use disorder or condition benefits and medical and surgical benefits within each classification of benefits.

(6) The results of an analysis that demonstrates that for the medical necessity criteria described in subparagraph (A) and for each nonquantitative treatment limitation identified in subparagraph (B), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental, emotional, nervous, or substance use disorder or condition benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(B) identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) disclose the specific findings and conclusions reached by the insurer that the results of the analyses described in subparagraphs (C) and (D) indicate that the insurer is in compliance with this Section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations, which includes 42 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(7) Any other information necessary to clarify data provided in accordance with this Section requested by the Director, including information that may be proprietary or have commercial value, under the requirements of Section 30 of the Viatical Settlements Act of 2009.

(l) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions on or after January 1, 2019 (the effective date of Public Act 100-1024) shall, in advance of the plan year, make available to the Department or, with respect to medical assistance, the Department of Healthcare and Family Services and to all plan participants and beneficiaries the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k). For plan

participants and medical assistance beneficiaries, the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k) shall be made available on a publicly available website whose web address is prominently displayed in plan and managed care organization informational and marketing materials.

(m) In conjunction with its compliance examination program conducted in accordance with the Illinois State Auditing Act, the Auditor General shall undertake a review of compliance by the Department and the Department of Healthcare and Family Services with Section 370c and this Section. Any findings resulting from the review conducted under this Section shall be included in the applicable State agency's compliance examination report. Each compliance examination report shall be issued in accordance with Section 3-14 of the Illinois State Auditing Act. A copy of each report shall also be delivered to the head of the applicable State agency and posted on the Auditor General's website.

(Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21; 102-813, eff. 5-13-22; 103-94, eff. 1-1-24; 103-105, eff. 6-27-23; 103-605, eff. 7-1-24.)

(215 ILCS 5/1563)

Sec. 1563. Fees. The fees required by this Article are as follows:

(1) Public adjuster license fee of \$250 for a person who is a resident of Illinois and \$500 for a person who is not a resident of Illinois, payable once every 2 years.

(2) Business entity license fee of \$250, payable once every 2 years.

(3) Application fee of \$50 for processing each request to take the written examination for a public adjuster license.

(Source: P.A. 100-863, eff. 8-14-18.)

Section 10. The Dental Care Patient Protection Act is amended by changing Section 75 as follows:

(215 ILCS 109/75)

Sec. 75. Application of other law.

(a) All provisions of this Act and other applicable law that are not in conflict with this Act shall apply to managed care dental plans and other persons subject to this Act. To the extent that any provision of this Act or rule under this Act would prevent the application of any standard or requirement under the Network Adequacy and Transparency Act to a plan that is subject to both statutes, the Network Adequacy and Transparency Act shall supersede this Act.

(b) Solicitation of enrollees by a managed care entity granted a certificate of authority or its representatives shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(Source: P.A. 91-355, eff. 1-1-00.)

Section 15. The Network Adequacy and Transparency Act is amended by changing Sections 3, 5, 10, and 25 as follows:

(215 ILCS 124/3)

Sec. 3. Applicability of Act. This Act applies to an individual or group policy of health insurance coverage with a network plan amended, delivered, issued, or renewed in this State on or after January 1, 2019. This Act does not apply to an individual or group policy for excepted benefits or short-term, limited-duration health insurance coverage with a network plan. This Act does not apply to stand-alone dental plans. If federal law establishes network adequacy and transparency standards for stand-alone dental plans, the Department shall enforce those applicable federal requirements, except to the extent that federal law establishes network adequacy and transparency standards for stand-alone dental plans, which the Department shall enforce for plans amended, delivered, issued, or renewed on or after January 1, 2025.

(Source: P.A. 103-650, eff. 1-1-25; 103-777, eff. 1-1-25; revised 11-26-24.)

(215 ILCS 124/5)

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

Sec. 5. Definitions. In this Act:

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

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under

a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an issuer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Essential community provider" has the meaning given ascribed to that term in 45 CFR 156.235.

"Excepted benefits" has the meaning given ascribed to that term in 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted benefits" includes individual, group, or blanket coverage.

"Exchange" has the meaning given ascribed to that term in 45 CFR 155.20.

~~"Director" means the Director of Insurance.~~

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

"Group health plan" has the meaning given ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the meaning given ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers within any county, the removal of a major health system that causes a network to be significantly different within any county from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

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

"Network plan" means an individual or group policy of health insurance coverage that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the issuer or by a third party contracted to arrange, contract for, or administer such provider-related incentives for the issuer.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, post-operative visits, or a serious and complex condition as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; (4) the third trimester of pregnancy through the post-partum period; (5) undergoing a course of institutional or inpatient care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of preoperative or postoperative care from such provider with respect to such a surgery; (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider; or (8) any other treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a provider because of the potential for changes in the therapeutic regimen or because of the potential for a recurrence of symptoms.

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

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions or facilities that provide health care services.

~~"Short-term, limited-duration insurance" means any type of accident and health insurance offered or provided within this State pursuant to a group or individual policy or individual certificate by a company, regardless of the situs state of the delivery of the policy, that has an expiration date specified in the contract that is fewer than 365 days after the original effective date. Regardless of the duration of coverage,~~

~~"short term, limited duration insurance" does not include excepted benefits or any student health insurance coverage.~~

"Stand-alone dental plan" has the meaning given ascribed to that term in 45 CFR 156.400.

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

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

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

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

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22; 103-650, eff. 1-1-25.)

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

Sec. 5. Definitions. In this Act:

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

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses or of the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an ~~issuer~~ insurer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Essential community provider" has the meaning given to that term in 45 CFR 156.235.

"Excepted benefits" has the meaning given to that term in 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted benefits" includes individual, group, or blanket coverage.

"Exchange" has the meaning given to that term in 45 CFR 155.20.

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

"Group health plan" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers compensation insurance, and pharmacy benefit managers.

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers within any county, the removal of a major health system that causes a network to be significantly different within any county from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

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

"Network plan" means an individual or group policy of ~~accident and~~ health insurance coverage that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the issuer or by a third party contracted to arrange, contract for, or administer such provider-related incentives for the issuer ~~insurer~~.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, ~~or~~ post-operative visits, or a serious and complex condition as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; ~~or~~ (4) the third trimester of pregnancy through the post-partum period; (5) undergoing a course of institutional or inpatient care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of preoperative or postoperative care from such provider with respect to such a surgery; (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider; or (8) any other treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a provider because of the potential for changes in the therapeutic regimen or because of the potential for a recurrence of symptoms.

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

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions or facilities that provide health care services.

"Stand-alone dental plan" has the meaning given to that term in 45 CFR 156.400.

"Telehealth" has the meaning given to that term in Section 3562.22 of the Illinois Insurance Code.

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

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

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22; 103-718, eff. 7-19-24.)

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

Sec. 5. Definitions. In this Act:

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

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an ~~issuer~~ insurer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Essential community provider" has the meaning given to that term in 45 CFR 156.235.

"Excepted benefits" has the meaning given to that term in 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted benefits" includes individual, group, or blanket coverage.

"Exchange" has the meaning given to that term in 45 CFR 155.20.

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

"Group health plan" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act. ~~"Insurer" means any entity that offers individual or group accident and~~

~~health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers compensation insurance, and pharmacy benefit managers.~~

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers within any county, the removal of a major health system that causes a network to be significantly different within any county from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

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

"Network plan" means an individual or group policy of ~~accident and~~ health insurance coverage that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the issuer or by a third party contracted to arrange, contract for, or administer such provider-related incentives for the issuer insurer.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, ~~or~~ post-operative visits, or a serious and complex condition as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; ~~or~~ (4) the third trimester of pregnancy through the post-partum period; (5) undergoing a course of institutional or inpatient care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of preoperative or postoperative care from such provider with respect to such a surgery; (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider; or (8) any other treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a provider because of the potential for changes in the therapeutic regimen or because of the potential for a recurrence of symptoms.

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

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions or facilities that provide health care services.

~~"Short-term, limited duration health insurance coverage has the meaning given to that term in Section 5 of the Short Term, Limited Duration Health Insurance Coverage Act.~~

"Stand-alone dental plan" has the meaning given to that term in 45 CFR 156.400.

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

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

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

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

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22; 103-777, eff. 1-1-25.)

(215 ILCS 124/10)

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

Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the ~~issuer insurer~~ does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the issuer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

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

(8) A limitation that ~~complies with subsections (d) and (e) of Section 55 of the Prior Authorization Reform Act, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed \$1,000 per occurrence in addition to the plan cost sharing provisions.~~

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

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

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

- (A) Primary Care;
- (B) Pediatrics;
- (C) Cardiology;
- (D) Gastroenterology;
- (E) General Surgery;
- (F) Neurology;
- (G) OB/GYN;
- (H) Oncology/Radiation;
- (I) Ophthalmology;
- (J) Urology;
- (K) Behavioral Health;
- (L) Allergy/Immunology;
- (M) Chiropractic;
- (N) Dermatology;
- (O) Endocrinology;
- (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- (Q) Infectious Disease;
- (R) Nephrology;
- (S) Neurosurgery;
- (T) Orthopedic Surgery;
- (U) Physiatry/Rehabilitative;
- (V) Plastic Surgery;
- (W) Pulmonary;
- (X) Rheumatology;
- (Y) Anesthesiology;
- (Z) Pain Medicine;
- (AA) Pediatric Specialty Services;
- (BB) Outpatient Dialysis; and
- (CC) HIV.

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

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

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are

more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

(d) The network plan shall demonstrate to the Director maximum travel and distance standards and appointment ~~wait-time~~ ~~wait-time~~ standards for plan beneficiaries, which shall be established by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

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

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

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment ~~wait-time~~ ~~wait-time~~ standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

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

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

emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

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

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the issuer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

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

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

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

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

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

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

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

(h) Issuers are required to report to the Director any material change to an approved network plan within 15 business days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 business days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of \$5,000 per day.

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

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a civil penalty of \$5,000 per policy.

(k) For the Department to enforce any new or modified federal standard before the Department adopts the standard by rule, the Department must, no later than May 15 before the start of the plan year, give public notice to the affected health insurance issuers through a bulletin.
(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

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

Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the ~~issuer insurer~~ does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the ~~issuer insurer~~ shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

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

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

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

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

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

- (F) Neurology;
- (G) OB/GYN;
- (H) Oncology/Radiation;
- (I) Ophthalmology;
- (J) Urology;
- (K) Behavioral Health;
- (L) Allergy/Immunology;
- (M) Chiropractic;
- (N) Dermatology;
- (O) Endocrinology;
- (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- (Q) Infectious Disease;
- (R) Nephrology;
- (S) Neurosurgery;
- (T) Orthopedic Surgery;
- (U) Physiatry/Rehabilitative;
- (V) Plastic Surgery;
- (W) Pulmonary;
- (X) Rheumatology;
- (Y) Anesthesiology;
- (Z) Pain Medicine;
- (AA) Pediatric Specialty Services;
- (BB) Outpatient Dialysis; and
- (CC) HIV.

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

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

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

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

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

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait-time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and

Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

(d-5)(1) Every issuer ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. ~~Issuers Insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

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

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the issuer ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

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

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

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

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

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

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

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

(h) Issuers ~~insurers~~ are required to report to the Director any material change to an approved network plan within 15 business days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer ~~insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 business days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of \$5,000 per day.

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

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a civil penalty of \$5,000 per policy.

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

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

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

Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) A limitation that complies with subsections (d) and (e) of Section 55 of the Prior Authorization Reform Act, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed \$1,000 per occurrence in addition to the plan cost sharing provisions.

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

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

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

- (A) Primary Care;
- (B) Pediatrics;
- (C) Cardiology;
- (D) Gastroenterology;
- (E) General Surgery;
- (F) Neurology;
- (G) OB/GYN;
- (H) Oncology/Radiation;
- (I) Ophthalmology;
- (J) Urology;
- (K) Behavioral Health;
- (L) Allergy/Immunology;
- (M) Chiropractic;
- (N) Dermatology;
- (O) Endocrinology;
- (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- (Q) Infectious Disease;
- (R) Nephrology;
- (S) Neurosurgery;
- (T) Orthopedic Surgery;

- (U) Physiatry/Rehabilitative;
- (V) Plastic Surgery;
- (W) Pulmonary;
- (X) Rheumatology;
- (Y) Anesthesiology;
- (Z) Pain Medicine;
- (AA) Pediatric Specialty Services;
- (BB) Outpatient Dialysis; and
- (CC) HIV.

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

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

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

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

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

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait-time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

If the federal Centers for Medicare and Medicaid Services establishes appointment wait-time standards for qualified health plans, including stand-alone dental plans, in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for the same types of qualified health plans for that plan year. If the federal Centers for Medicare and Medicaid Services establishes time

and distance standards for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d-5)(1) Every ~~issuer~~ ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. ~~Issuers~~ ~~Insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

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

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the ~~issuer~~ ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

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

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

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

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

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

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

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

(h) ~~Issuers insurers~~ are required to report to the Director any material change to an approved network plan within 15 business days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the ~~issuer insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 business days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of \$5,000 per day.

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

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a civil penalty of \$5,000 per policy.

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

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

(Text of Section from P.A. 103-777)
Sec. 10. Network adequacy.

[May 8, 2025]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the issuer ~~insurer~~ does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the issuer ~~insurer~~ shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

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

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

(8) A limitation that complies with subsections (d) and (e) of Section 55 of the Prior Authorization Reform Act, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed \$1,000 per occurrence in addition to the plan cost sharing provisions.

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

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

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

- (A) Primary Care;
- (B) Pediatrics;
- (C) Cardiology;
- (D) Gastroenterology;
- (E) General Surgery;
- (F) Neurology;
- (G) OB/GYN;
- (H) Oncology/Radiation;
- (I) Ophthalmology;
- (J) Urology;
- (K) Behavioral Health;
- (L) Allergy/Immunology;
- (M) Chiropractic;
- (N) Dermatology;
- (O) Endocrinology;
- (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- (Q) Infectious Disease;
- (R) Nephrology;
- (S) Neurosurgery;
- (T) Orthopedic Surgery;
- (U) Physiatry/Rehabilitative;
- (V) Plastic Surgery;
- (W) Pulmonary;
- (X) Rheumatology;
- (Y) Anesthesiology;
- (Z) Pain Medicine;
- (AA) Pediatric Specialty Services;
- (BB) Outpatient Dialysis; and
- (CC) HIV.

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

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

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

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

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

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait-time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

(d-5)(1) Every issuer ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. ~~Issuers~~ ~~insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for

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

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

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

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the issuer ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

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

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

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

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

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

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

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

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

(h) Issuers ~~insurers~~ are required to report to the Director any material change to an approved network plan within 15 business days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer ~~insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 business days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of \$5,000 per day.

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

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a civil penalty of \$5,000 per policy.

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

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

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

Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the issuer ~~insurer~~ does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the issuer ~~insurer~~ shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

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

(8) A limitation that complies with subsections (d) and (e) of Section 55 of the Prior Authorization Reform Act, ~~if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed \$1,000 per occurrence in addition to the plan cost sharing provisions.~~

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

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

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

- (A) Primary Care;
- (B) Pediatrics;
- (C) Cardiology;
- (D) Gastroenterology;
- (E) General Surgery;
- (F) Neurology;
- (G) OB/GYN;
- (H) Oncology/Radiation;
- (I) Ophthalmology;
- (J) Urology;
- (K) Behavioral Health;
- (L) Allergy/Immunology;
- (M) Chiropractic;
- (N) Dermatology;
- (O) Endocrinology;
- (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- (Q) Infectious Disease;
- (R) Nephrology;
- (S) Neurosurgery;
- (T) Orthopedic Surgery;
- (U) Physiatry/Rehabilitative;
- (V) Plastic Surgery;
- (W) Pulmonary;
- (X) Rheumatology;
- (Y) Anesthesiology;
- (Z) Pain Medicine;
- (AA) Pediatric Specialty Services;
- (BB) Outpatient Dialysis; and
- (CC) HIV.

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

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

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

(d) The network plan shall demonstrate to the Director maximum travel and distance standards and appointment wait-time standards for plan beneficiaries, which shall be established ~~annually~~ by the

Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

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

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

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait-time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

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

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

(d-5)(1) Every issuer ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. ~~Issuers~~ ~~insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a

beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

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

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the ~~issuer~~ ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

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

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

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

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

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

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

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

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

issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of \$5,000 per day.

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

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a civil penalty of \$5,000 per policy.

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

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

(215 ILCS 124/25)

(Text of Section from P.A. 103-605)

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of \$5,000 per month. ~~The network plan shall update the online provider directory at least monthly.~~ Providers shall notify the network plan electronically or in writing within 10 business days of any changes to their information as listed in the provider directory, including the information required in subsections (b), (c), and (d) ~~subparagraph (K) of paragraph (1) of subsection (b).~~ With regard to ~~subparagraph (I) of paragraph (1) of subsection (b),~~ the provider must give notice to the issuer within 20 business days of deciding to cease accepting new patients covered by the plan if the new patient limitation is expected to last 40 business days or longer. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 ~~to~~ business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the issuer shall self-audit each network plan's ~~The network plan shall audit periodically at least 25% of its~~ provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The issuer shall submit the self-audit and a summary to the Department, and the Department shall make the summary of each self-audit publicly available. ~~The Department shall specify the requirements of the summary, which shall be statistical in nature except for a high-level narrative evaluating the impact of internal and external factors on the accuracy of the directory and the timeliness of updates. The network plan shall submit the audit to the Director upon request.~~ As part of these self-audits ~~audits,~~ the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network. The self-audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

(4) A network plan shall provide a printed copy of a current provider directory or a printed copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Except when an issuer's printed copies use the same provider information as the electronic provider

directory on each printed copy's date of printing, printed ~~Printed~~ copies must be updated at least every 90 days ~~quarterly~~ and an errata that reflects changes in the provider network must be included in each update updated quarterly.

(5) For each network plan, a network plan shall include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the issuer insurer or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier; ~~and~~

(D) if applicable, a notation that authorization or referral may be required to access some providers;-

(E) a telephone number and email address for a customer service representative to whom directory inaccuracies may be reported; and

(F) a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute such charges.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) patient population served (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable; ~~and~~

(K) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(L) whether the health care professional accepts appointment requests from patients; and

(M) the anticipated date the provider will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms that the provider is scheduled to leave the network;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer);

(C) participating hospital location; ~~and~~

(D) hospital accreditation status; and

(E) the anticipated date the hospital will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the hospital is scheduled to leave the network; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; ~~and~~

(D) participating facility location or locations; ~~and~~

(E) the anticipated date the facility will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the facility is scheduled to leave the network.

(c) For the electronic provider directories, for each network plan, a network plan shall make available all of the following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information, including both a telephone number and digital contact information if the provider has supplied digital contact information; and

(B) languages spoken other than English by clinical staff, if applicable;

(2) for hospitals, telephone number and digital contact information; and

(3) for facilities other than hospitals, telephone number.

(d) The issuer ~~insurer~~ or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information, including a telephone number and digital contact information if the provider has supplied digital contact information;

(C) participating office location or locations;

(D) patient population (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) languages spoken other than English, if applicable;

(F) whether accepting new patients; ~~and~~

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent; and

(H) whether the health care professional accepts appointment requests from patients;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer); and

(C) participating hospital location, ~~and~~ telephone number, and digital contact information; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) patient population (such as pediatric, adult, elderly, or women) served, if applicable, and types of services performed; and

(D) participating facility location or locations, ~~and~~ telephone numbers, and digital contact information for each location.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the issuer's ~~insurer's~~ electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number and email address in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information or report provider directory inaccuracies. The printed provider directory shall include a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute those charges.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300gg-115, except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Section.

(h) If the issuer or the Department identifies a provider incorrectly listed in the provider directory, the issuer shall check each of the issuer's network plan provider directories for the provider within 2 business days to ascertain whether the provider is a preferred provider in that network plan and, if the provider is incorrectly listed in the provider directory, remove the provider from the provider directory without delay.

(i) If the Director determines that an issuer violated this Section, the Director may assess a fine up to \$5,000 per violation, except for inaccurate information given by a provider to the issuer. If an issuer, or any entity or person acting on the issuer's behalf, knew or reasonably should have known that a provider was incorrectly included in a provider directory, the Director may assess a fine of up to \$25,000 per violation against the issuer.

(j) This Section applies to network plans not otherwise exempt under Section 3.

(Source: P.A. 102-92, eff. 7-9-21; 103-605, eff. 7-1-24.)

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

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of \$5,000 per month. Providers shall notify the network plan electronically or in writing within 10 business days of any changes to their information as listed in the provider directory, including the information required in subsections (b), (c), and (d). With regard to subparagraph (I) of paragraph (1) of subsection (b), the provider must give notice to the issuer within 20 business days of deciding to cease accepting new patients covered by the plan if the new patient limitation is expected to last 40 business days or longer. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the issuer shall self-audit each network plan's provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The issuer shall submit the self-audit and a summary to the Department, and the Department shall make the summary of each self-audit publicly available. The Department shall specify the requirements of the summary, which shall be statistical in nature except for a high-level narrative evaluating the impact of internal and external factors on the accuracy of the directory and the timeliness of updates. As part of these self-audits, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in

the plan's network. The self-audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

(4) A network plan shall provide a printed print copy of a current provider directory or a printed print copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Except when an issuer's printed print copies use the same provider information as the electronic provider directory on each printed print copy's date of printing, printed print copies must be updated at least every 90 days and errata that reflects changes in the provider network must be included in each update.

(5) For each network plan, a network plan shall include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the issuer or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier;

(D) if applicable, a notation that authorization or referral may be required to access some providers;

(E) a telephone number and email address for a customer service representative to whom directory inaccuracies may be reported; and

(F) a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute such charges.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) patient population served (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable;

(K) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

- (iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;
 - (L) whether the health care professional accepts appointment requests from patients; and
 - (M) the anticipated date the provider will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms that the provider is scheduled to leave the network;
- (2) for hospitals:
- (A) hospital name;
 - (B) hospital type (such as acute, rehabilitation, children's, or cancer);
 - (C) participating hospital location;
 - (D) hospital accreditation status; and
 - (E) the anticipated date the hospital will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the hospital is scheduled to leave the network; and
- (3) for facilities, other than hospitals, by type:
- (A) facility name;
 - (B) facility type;
 - (C) types of services performed;
 - (D) participating facility location or locations; and
 - (E) the anticipated date the facility will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the facility is scheduled to leave the network.
- (c) For the electronic provider directories, for each network plan, a network plan shall make available all of the following information in addition to the searchable information required in this Section:
- (1) for health care professionals:
 - (A) contact information, including both a telephone number and digital contact information if the provider has supplied digital contact information; and
 - (B) languages spoken other than English by clinical staff, if applicable;
 - (2) for hospitals, telephone number and digital contact information; and
 - (3) for facilities other than hospitals, telephone number.
- (d) The issuer or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:
- (1) for health care professionals:
 - (A) name;
 - (B) contact information, including a telephone number and digital contact information if the provider has supplied digital contact information;
 - (C) participating office location or locations;
 - (D) patient population (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;
 - (E) languages spoken other than English, if applicable;
 - (F) whether accepting new patients;
 - (G) use of telehealth or telemedicine, including, but not limited to:
 - (i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;
 - (ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and
 - (iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent; and
 - (H) whether the health care professional accepts appointment requests from patients;
 - (2) for hospitals:
 - (A) hospital name;
 - (B) hospital type (such as acute, rehabilitation, children's, or cancer); and
 - (C) participating hospital location, telephone number, and digital contact information; and
 - (3) for facilities, other than hospitals, by type:

- (A) facility name;
- (B) facility type;
- (C) patient population (such as pediatric, adult, elderly, or women) served, if applicable, and types of services performed; and
- (D) participating facility location or locations, telephone numbers, and digital contact information for each location.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the issuer's electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number and email address in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information or report provider directory inaccuracies. The printed provider directory shall include a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute those charges.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300gg-115, except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Section.

(h) If the issuer or the Department identifies a provider incorrectly listed in the provider directory, the issuer shall check each of the issuer's network plan provider directories for the provider within 2 business days to ascertain whether the provider is a preferred provider in that network plan and, if the provider is incorrectly listed in the provider directory, remove the provider from the provider directory without delay.

(i) If the Director determines that an issuer violated this Section, the Director may assess a fine up to \$5,000 per violation, except for inaccurate information given by a provider to the issuer. If an issuer, or any entity or person acting on the issuer's behalf, knew or reasonably should have known that a provider was incorrectly included in a provider directory, the Director may assess a fine of up to \$25,000 per violation against the issuer.

(j) This Section applies to network plans not otherwise exempt under Section 3-~~including stand-alone dental plans.~~

(Source: P.A. 102-92, eff. 7-9-21; 103-650, eff. 1-1-25.)

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

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of \$5,000 per month. The network plan shall update the online provider directory at least monthly. Providers shall notify the network plan electronically or in writing within 10 business days of any changes to their information as listed in the provider directory, including the information required in subsections (b), (c), and (d) ~~subparagraph (K) of paragraph (1) of subsection (b).~~ With regard to subparagraph (1) of paragraph (1) of subsection (b), the provider must give notice to the issuer within 20 business days of deciding to cease accepting new patients covered by the plan if the new patient limitation is expected to last 40 business days or longer. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within ~~2-40~~ 20 business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the issuer shall self-audit each network plan's ~~The network plan shall audit periodically at least 25% of its~~ provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The issuer shall submit the self-audit and a summary to the Department, and the Department shall make the summary of each self-audit publicly available.

The Department shall specify the requirements of the summary, which shall be statistical in nature except for a high-level narrative evaluating the impact of internal and external factors on the accuracy of the directory and the timeliness of updates. ~~The network plan shall submit the audit to the Director upon request.~~ As part of these self-audits ~~audits~~, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network. The self-audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

(4) A network plan shall provide a printed copy of a current provider directory or a printed copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Except when an issuer's printed copies use the same provider information as the electronic provider directory on each printed copy's date of printing, ~~printed~~ Printed copies must be updated at least every 90 days ~~quarterly~~ and ~~an~~ errata that reflects changes in the provider network must be included in each update ~~updated quarterly~~.

(5) For each network plan, a network plan shall include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the issuer ~~insurer~~ or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier; ~~and~~

(D) if applicable, a notation that authorization or referral may be required to access some providers;-

(E) a telephone number and email address for a customer service representative to whom directory inaccuracies may be reported; and

(F) a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute such charges.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) patient population served (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable; ~~and~~

(K) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(L) whether the health care professional accepts appointment requests from patients; and

(M) the anticipated date the provider will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms that the provider is scheduled to leave the network;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer);

(C) participating hospital location; ~~and~~

(D) hospital accreditation status; and

(E) the anticipated date the hospital will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the hospital is scheduled to leave the network; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; ~~and~~

(D) participating facility location or locations; ~~and-~~

(E) the anticipated date the facility will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the facility is scheduled to leave the network.

(c) For the electronic provider directories, for each network plan, a network plan shall make available all of the following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information, including both a telephone number and digital contact information if the provider has supplied digital contact information; and

(B) languages spoken other than English by clinical staff, if applicable;

(2) for hospitals, telephone number and digital contact information; and

(3) for facilities other than hospitals, telephone number.

(d) The issuer ~~insurer~~ or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information, including a telephone number and digital contact information if the provider has supplied digital contact information;

(C) participating office location or locations;

(D) patient population (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) languages spoken other than English, if applicable;

(F) whether accepting new patients; ~~and~~

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent; and

(H) whether the health care professional accepts appointment requests from patients;

- (2) for hospitals:
- (A) hospital name;
 - (B) hospital type (such as acute, rehabilitation, children's, or cancer); and
 - (C) participating hospital location, and telephone number, and digital contact information;
- and
- (3) for facilities, other than hospitals, by type:
- (A) facility name;
 - (B) facility type;
 - (C) patient population (such as pediatric, adult, elderly, or women) served, if applicable, and types of services performed; and
 - (D) participating facility location or locations, and telephone numbers, and digital contact information for each location.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the issuer's insurer's electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number and email address in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information or report provider directory inaccuracies. The printed provider directory shall include a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute those charges.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300gg-115, except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Section.

(h) If the issuer or the Department identifies a provider incorrectly listed in the provider directory, the issuer shall check each of the issuer's network plan provider directories for the provider within 2 business days to ascertain whether the provider is a preferred provider in that network plan and, if the provider is incorrectly listed in the provider directory, remove the provider from the provider directory without delay.

(i) If the Director determines that an issuer violated this Section, the Director may assess a fine up to \$5,000 per violation, except for inaccurate information given by a provider to the issuer. If an issuer, or any entity or person acting on the issuer's behalf, knew or reasonably should have known that a provider was incorrectly included in a provider directory, the Director may assess a fine of up to \$25,000 per violation against the issuer.

(j) ~~(g)~~ This Section applies to network plans that are not otherwise exempt under Section 3, including stand-alone dental plans that are subject to provider directory requirements under federal law.

(Source: P.A. 102-92, eff. 7-9-21; 103-777, eff. 1-1-25.)

Section 20. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2,

409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance

Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

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

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

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

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

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

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

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

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

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

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

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger,

consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

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

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

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

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

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

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

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

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

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

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

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

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

(g) 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. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;

103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 25. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

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

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c, 355.2, 355.3, 355b, 355d, 356m, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 356z.71, 356z.73, 356z.74, 356z.75, 364.3, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, ~~and~~ XXVI, and XXXIIB of the Illinois Insurance Code. Nothing in this Section shall require a limited health care plan to cover any service that is not a limited health service. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

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

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

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 30. The Criminal Code of 2012 is amended by changing Section 17-0.5 as follows:

(720 ILCS 5/17-0.5)

Sec. 17-0.5. Definitions. In this Article:

"Altered credit card or debit card" means any instrument or device, whether known as a credit card or debit card, which has been changed in any respect by addition or deletion of any material, except for the signature by the person to whom the card is issued.

"Cardholder" means the person or organization named on the face of a credit card or debit card to whom or for whose benefit the credit card or debit card is issued by an issuer.

"Computer" means a device that accepts, processes, stores, retrieves, or outputs data and includes, but is not limited to, auxiliary storage, including cloud-based networks of remote services hosted on the Internet, and telecommunications devices connected to computers.

"Computer network" means a set of related, remotely connected devices and any communications facilities including more than one computer with the capability to transmit data between them through the communications facilities.

"Computer program" or "program" means a series of coded instructions or statements in a form acceptable to a computer which causes the computer to process data and supply the results of the data processing.

"Computer services" means computer time or services, including data processing services, Internet services, electronic mail services, electronic message services, or information or data stored in connection therewith.

"Counterfeit" means to manufacture, produce or create, by any means, a credit card or debit card without the purported issuer's consent or authorization.

"Credit card" means any instrument or device, whether known as a credit card, credit plate, charge plate or any other name, issued with or without fee by an issuer for the use of the cardholder in obtaining

money, goods, services or anything else of value on credit or in consideration or an undertaking or guaranty by the issuer of the payment of a check drawn by the cardholder.

"Data" means a representation in any form of information, knowledge, facts, concepts, or instructions, including program documentation, which is prepared or has been prepared in a formalized manner and is stored or processed in or transmitted by a computer or in a system or network. Data is considered property and may be in any form, including, but not limited to, printouts, magnetic or optical storage media, punch cards, or data stored internally in the memory of the computer.

"Debit card" means any instrument or device, known by any name, issued with or without fee by an issuer for the use of the cardholder in obtaining money, goods, services, and anything else of value, payment of which is made against funds previously deposited by the cardholder. A debit card which also can be used to obtain money, goods, services and anything else of value on credit shall not be considered a debit card when it is being used to obtain money, goods, services or anything else of value on credit.

"Document" includes, but is not limited to, any document, representation, or image produced manually, electronically, or by computer.

"Electronic fund transfer terminal" means any machine or device that, when properly activated, will perform any of the following services:

- (1) Dispense money as a debit to the cardholder's account; or
- (2) Print the cardholder's account balances on a statement; or
- (3) Transfer funds between a cardholder's accounts; or
- (4) Accept payments on a cardholder's loan; or
- (5) Dispense cash advances on an open end credit or a revolving charge agreement; or
- (6) Accept deposits to a customer's account; or
- (7) Receive inquiries of verification of checks and dispense information that verifies that funds are available to cover such checks; or
- (8) Cause money to be transferred electronically from a cardholder's account to an account held by any business, firm, retail merchant, corporation, or any other organization.

"Electronic funds transfer system", hereafter referred to as "EFT System", means that system whereby funds are transferred electronically from a cardholder's account to any other account.

"Electronic mail service provider" means any person who (i) is an intermediary in sending or receiving electronic mail and (ii) provides to end-users of electronic mail services the ability to send or receive electronic mail.

"Expired credit card or debit card" means a credit card or debit card which is no longer valid because the term on it has elapsed.

"False academic degree" means a certificate, diploma, transcript, or other document purporting to be issued by an institution of higher learning or purporting to indicate that a person has completed an organized academic program of study at an institution of higher learning when the person has not completed the organized academic program of study indicated on the certificate, diploma, transcript, or other document.

"False claim" means any statement made to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any agent or employee of one of those entities, and made as part of, or in support of, a claim for payment or other benefit under a policy of insurance, or as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, when the statement does any of the following:

- (1) Contains any false, incomplete, or misleading information concerning any fact or thing material to the claim.
- (2) Conceals (i) the occurrence of an event that is material to any person's initial or continued right or entitlement to any insurance benefit or payment or (ii) the amount of any benefit or payment to which the person is entitled.

"Financial institution" means any bank, savings and loan association, credit union, or other depository of money or medium of savings and collective investment.

"Governmental entity" means: each officer, board, commission, and agency created by the Constitution, whether in the executive, legislative, or judicial branch of State government; each officer, department, board, commission, agency, institution, authority, university, and body politic and corporate of the State; each administrative unit or corporate outgrowth of State government that is created by or pursuant to statute, including units of local government and their officers, school districts, and boards of election commissioners; and each administrative unit or corporate outgrowth of the foregoing items and as may be created by executive order of the Governor.

"Incomplete credit card or debit card" means a credit card or debit card which is missing part of the matter other than the signature of the cardholder which an issuer requires to appear on the credit card or debit card before it can be used by a cardholder, and this includes credit cards or debit cards which have not been stamped, embossed, imprinted or written on.

"Institution of higher learning" means a public or private college, university, or community college located in the State of Illinois that is authorized by the Board of Higher Education or the Illinois Community College Board to issue post-secondary degrees, or a public or private college, university, or community college located anywhere in the United States that is or has been legally constituted to offer degrees and instruction in its state of origin or incorporation.

"Insurance company" means any "company" as defined under Section 2 of the Illinois Insurance Code, "dental service plan corporation" as defined in Section 3 of the Dental Service Plan Act, "health maintenance organization" as defined in Section 1-2 of the Health Maintenance Organization Act, "limited health service organization" as defined in Section 1002 of the Limited Health Service Organization Act, "health services plan corporation" as defined in Section 2 of the Voluntary Health Services Plans Act, or any trust fund organized under the Religious and Charitable Risk Pooling Trust Act.

"Issuer" means the business organization or financial institution which issues a credit card or debit card, or its duly authorized agent.

"Merchant" has the meaning ascribed to it in Section 16-0.1 of this Code.

"Person" means any individual, corporation, government, governmental subdivision or agency, business trust, estate, trust, partnership or association or any other entity.

"Receives" or "receiving" means acquiring possession or control.

"Record of charge form" means any document submitted or intended to be submitted to an issuer as evidence of a credit transaction for which the issuer has agreed to reimburse persons providing money, goods, property, services or other things of value.

"Revoked credit card or debit card" means a credit card or debit card which is no longer valid because permission to use it has been suspended or terminated by the issuer.

"Sale" means any delivery for value.

"Scheme or artifice to defraud" includes a scheme or artifice to deprive another of the intangible right to honest services.

"Self-insured entity" means any person, business, partnership, corporation, or organization that sets aside funds to meet his, her, or its losses or to absorb fluctuations in the amount of loss, the losses being charged against the funds set aside or accumulated.

"Social networking website" means an Internet website containing profile web pages of the members of the website that include the names or nicknames of such members, photographs placed on the profile web pages by such members, or any other personal or personally identifying information about such members and links to other profile web pages on social networking websites of friends or associates of such members that can be accessed by other members or visitors to the website. A social networking website provides members of or visitors to such website the ability to leave messages or comments on the profile web page that are visible to all or some visitors to the profile web page and may also include a form of electronic mail for members of the social networking website.

"Statement" means any assertion, oral, written, or otherwise, and includes, but is not limited to: any notice, letter, or memorandum; proof of loss; bill of lading; receipt for payment; invoice, account, or other financial statement; estimate of property damage; bill for services; diagnosis or prognosis; prescription; hospital, medical, or dental chart or other record, x-ray, photograph, videotape, or movie film; test result; other evidence of loss, injury, or expense; computer-generated document; and data in any form.

"Universal Price Code Label" means a unique symbol that consists of a machine-readable code and human-readable numbers.

"With intent to defraud" means to act knowingly, and with the specific intent to deceive or cheat, for the purpose of causing financial loss to another or bringing some financial gain to oneself, regardless of whether any person was actually defrauded or deceived. This includes an intent to cause another to assume, create, transfer, alter, or terminate any right, obligation, or power with reference to any person or property.

(Source: P.A. 101-87, eff. 1-1-20.)

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by

multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99. Effective date. This Act takes effect upon becoming law, except that the changes to Section 1563 of the Illinois Insurance Code take effect January 1, 2026, and the changes to Section 174 of the Illinois Insurance Code take effect 60 days after becoming law."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Morrison, **House Bill No. 3849** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Feigenholtz, **House Bill No. 2907** having been printed, was taken up, read by title a second time and ordered to a third reading.

READING BILLS OF THE SENATE A SECOND TIME

On motion of Senator Fine, **Senate Bill No. 2001** having been printed, was taken up, read by title a second time.

Committee Amendment No. 1 was postponed in the Committee on Judiciary.

The following amendment was offered in the Committee on Judiciary, adopted and ordered printed:

AMENDMENT NO. 2 TO SENATE BILL 2001

AMENDMENT NO. 2. Amend Senate Bill 2001 by replacing everything after the enacting clause with the following:

"Section 5. The Auction License Act is amended by changing Section 15-10 as follows:
(225 ILCS 407/15-10)

(Section scheduled to be repealed on January 1, 2030)

Sec. 15-10. Auction contract. Any auctioneer or auction firm shall not conduct an auction or provide an auction service, unless the auctioneer or auction firm enters into a written auction contract with the seller of any property at auction prior to the date of the auction. Any agreement shall state whether the auction is with reserve or absolute. The agreement shall be signed by the auctioneer or auction firm conducting an auction or providing an auction service and the seller or sellers, or the legal agent of the seller or sellers of the property to be offered at or by auction, and shall include, but not be limited to the following disclosures:

(1) Licensees shall disclose:

(A) the name, license number, business address, and phone number of the auctioneer or auction firm conducting an auction or providing an auction service;

(B) the fee to be paid to the auctioneer or auction firm for conducting an auction or providing an auction service;

(C) an estimate of the advertising costs that shall be paid by the seller or sellers of property at auction and a disclosure that, if the actual advertising costs exceeds 120% of the estimated advertising cost, the auctioneer or auction firm shall pay the advertising costs that exceed 120% of the estimated advertising costs or shall have the seller or sellers agree in writing to pay for the actual advertising costs in excess of 120% of the estimated advertising costs; and

(D) the buyer premium and the party to the transaction that receives it.

(2) Sellers shall disclose:

(A) the name, address, and phone number of the seller or sellers or the legal agent of the seller or sellers of property to be sold at auction; ~~and~~

(B) any mortgage, lien, easement, or encumbrance of which the seller has knowledge on any property or goods to be sold or leased at or by auction; ~~and -~~

(C) if known to the seller, an acknowledgment that (i) all property or goods offered for sale or by auction are owned by the seller, (ii) the seller has full legal authority to sell such

property or goods, and (iii) to the best of the seller's knowledge, the property or goods to be sold have been lawfully obtained.

(Source: P.A. 96-730, eff. 8-25-09; 96-1000, eff. 7-2-10.)".

There being no further amendments, the foregoing Amendment No. 2 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

On motion of Senator Hastings, **Senate Bill No. 2303** having been printed, was taken up, read by title a second time.

The following amendment was offered in the Committee on Local Government, adopted and ordered printed:

AMENDMENT NO. 1 TO SENATE BILL 2303

AMENDMENT NO. 1. Amend Senate Bill 2303 by replacing everything after the enacting clause with the following:

"Section 5. The Fire Sprinkler Contractor Licensing Act is amended by changing Section 62 as follows:

(225 ILCS 317/62)

Sec. 62. Unlicensed practice; violation; civil penalty.

(a) Any person, entity, or business that offers fire sprinkler contractor services under this Act without being licensed or exempt under this Act shall, in addition to any other penalty provided by law, pay a civil penalty, which shall be deposited into the Fire Prevention Fund, in an amount not to exceed \$10,000 for each offense, as determined by the Office. If any person, entity, or business commits a second offense within 24 months, the civil penalty shall be no less than \$10,000, which shall be deposited into the Fire Prevention Fund. If any person, entity, or business commits more than 2 offenses within 24 months, the civil penalty shall be no less than \$25,000, which shall be deposited into the Fire Prevention Fund. The civil penalty shall be assessed by the Office after a hearing is held in accordance with the provisions of this Act regarding the provision of a hearing for the discipline of a licensee.

(b) Use of the title "fire sprinkler inspector" is limited to those individuals licensed under this Act. Any person who practices, offers to practice, attempts to practice, or holds himself or herself out to practice as a fire sprinkler inspector without being licensed or exempt under this Act shall, in addition to any other penalty provided by law, pay a civil penalty, which shall be deposited into the Fire Prevention Fund, in an amount not to exceed \$10,000 for each offense, as determined by the Office. If any person commits a second offense within 24 months, the civil penalty shall be no less than \$10,000, which shall be deposited into the Fire Prevention Fund. If any person commits more than 2 offenses within 24 months, the civil penalty shall be no less than \$25,000, which shall be deposited into the Fire Prevention Fund. The civil penalty shall be assessed by the Office after a hearing is held in accordance with the provisions of this Act regarding the provision of a hearing for the discipline of a licensee.

(c) The Office may investigate any actual, alleged, or suspected unlicensed activity.

(d) The civil penalty shall be paid within 60 days after the effective date of the order imposing the civil penalty. The order shall constitute a final judgment and may be filed and execution had thereon in the same manner as any judgment from any court of record.

(Source: P.A. 102-612, eff. 8-27-21.)

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

There being no further amendments, the foregoing Amendment No. 1 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

On motion of Senator Hastings, **Senate Bill No. 2469** having been printed, was taken up, read by title a second time.

The following amendment was offered in the Committee on Licensed Activities, adopted and ordered printed:

AMENDMENT NO. 1 TO SENATE BILL 2469

AMENDMENT NO. 1. Amend Senate Bill 2469 on page 5, by inserting immediately below line 17 the following:

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

There being no further amendments, the foregoing Amendment No. 1 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator Martwick, **House Bill No. 1502** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Martwick, **House Bill No. 28** having been printed, was taken up, read by title a second time and ordered to a third reading.

At the hour of 12:59 o'clock p.m., the Chair announced that the Senate stands at ease.

AT EASE

At the hour of 1:06 o'clock p.m., the Senate resumed consideration of business.
Senator Koehler, presiding.

REPORT FROM COMMITTEE ON ASSIGNMENTS

Senator Lightford, Chair of the Committee on Assignments, during its May 8, 2025 meeting, reported the following Legislative Measures have been assigned to the indicated Standing Committees of the Senate:

Appropriations: **Senate Bills Numbered 2508, 2509, 2510, 2511 and 2512.**

Executive: **House Bills Numbered 1075, 1312, 1437, 1697, 1700, 1823, 1832, 1863, 1927, 1928, 2335, 2371, 2423, 2568, 2755, 2771, 2785, 2949, 2967, 3019, 3065, 3193, 3343, 3374, 3438, 3508, 3654, 3657, 3662 and 3790.**

Senator Lightford, Chair of the Committee on Assignments, during its May 8, 2025 meeting, reported that the following Legislative Measure has been approved for consideration:

Floor Amendment No. 3 to Senate Bill 1486

The foregoing floor amendment was placed on the Secretary's Desk.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator Lightford, **House Bill No. 3352** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Lightford, **House Bill No. 3772** was taken up, read by title a second time.
Committee Amendment No. 1 was held in the Committee on Assignments.

The following amendment was offered in the Committee on Education, adopted and ordered printed:

[May 8, 2025]

AMENDMENT NO. 2 TO HOUSE BILL 3772

AMENDMENT NO. 2. Amend House Bill 3772 by replacing everything after the enacting clause with the following:

"Section 5. The School Code is amended by changing Sections 2-3.162, 10-22.6, 13B-20.25, 13B-20.30, and 13B-25.5 as follows:

(105 ILCS 5/2-3.162)

Sec. 2-3.162. Student discipline report; school discipline improvement plan.

(a) On or before October 31, 2015 and on or before October 31 of each subsequent year, the State Board of Education, through the State Superintendent of Education, shall prepare a report on student discipline in all school districts in this State, including State-authorized charter schools. This report shall include data from all public schools within school districts, including district-authorized charter schools. This report must be posted on the Internet website of the State Board of Education. The report shall include data on the issuance of out-of-school suspensions, expulsions, and removals to alternative settings in lieu of another disciplinary action, disaggregated by race and ethnicity, gender, age, grade level, whether a student is an English learner, incident type, and discipline duration. Such data shall be reported to the State Board of Education annually by all school districts in this State, including State-authorized charter schools, in a form and manner specified by the State Board of Education, no later than July 31 for the previous school year and by July 31 of each year thereafter.

(b) The State Board of Education shall analyze the data under subsection (a) of this Section on an annual basis and determine the top 20% of school districts for the following metrics:

(1) Total number of out-of-school suspensions divided by the total district enrollment by the last school day in September for the year in which the data was collected, multiplied by 100.

(2) Total number of out-of-school expulsions divided by the total district enrollment by the last school day in September for the year in which the data was collected, multiplied by 100.

(3) Racial disproportionality, defined as the overrepresentation of students of color or white students in comparison to the total number of students of color or white students on October 1st of the school year in which data are collected, with respect to the use of out-of-school suspensions and expulsions, which must be calculated using the same method as the U.S. Department of Education's Office for Civil Rights uses.

The analysis must be based on data collected over 3 consecutive school years, beginning with the 2014-2015 school year.

Beginning with the 2017-2018 school year, the State Board of Education shall require each of the school districts that are identified in the top 20% of any of the metrics described in this subsection (b) for 3 consecutive years to submit a plan identifying the strategies the school district will implement to reduce the use of exclusionary disciplinary practices or racial disproportionality or both, if applicable. School districts that no longer meet the criteria described in any of the metrics described in this subsection (b) for 3 consecutive years shall no longer be required to submit a plan.

This plan may be combined with any other improvement plans required under federal or State law.

The calculation of the top 20% of any of the metrics described in this subsection (b) shall exclude all school districts, State-authorized charter schools, and special charter districts that issued fewer than a total of 10 out-of-school suspensions or expulsions, whichever is applicable, during the school year. The calculation of the top 20% of the metric described in subdivision (3) of this subsection (b) shall exclude all school districts with an enrollment of fewer than 50 white students or fewer than 50 students of color.

The plan must be approved at a public school board meeting and posted on the school district's Internet website. Within one year after being identified, the school district shall submit to the State Board of Education and post on the district's Internet website a progress report describing the implementation of the plan and the results achieved.

(Source: P.A. 99-30, eff. 7-10-15; 99-78, eff. 7-20-15; 100-863, eff. 8-14-18.)

(105 ILCS 5/10-22.6) (from Ch. 122, par. 10-22.6)

(Text of Section before amendment by P.A. 102-466)

Sec. 10-22.6. Suspension or expulsion of students; school searches.

(a) To expel students guilty of gross disobedience or misconduct, including gross disobedience or misconduct perpetuated by electronic means, pursuant to subsection (b-20) of this Section, and no action shall lie against them for such expulsion. Expulsion shall take place only after the parents have been requested to appear at a meeting of the board, or with a hearing officer appointed by it, to discuss their

child's behavior. Such request shall be made by registered or certified mail and shall state the time, place and purpose of the meeting. The board, or a hearing officer appointed by it, at such meeting shall state the reasons for dismissal and the date on which the expulsion is to become effective. If a hearing officer is appointed by the board, the hearing officer shall report to the board a written summary of the evidence heard at the meeting and the board may take such action thereon as it finds appropriate. If the board acts to expel a student, the written expulsion decision shall detail the specific reasons why removing the student from the learning environment is in the best interest of the school. The expulsion decision shall also include a rationale as to the specific duration of the expulsion. An expelled student may be immediately transferred to an alternative program in the manner provided in Article 13A or 13B of this Code. A student must not be denied transfer because of the expulsion, except in cases in which such transfer is deemed to cause a threat to the safety of students or staff in the alternative program.

(b) To suspend or by policy to authorize the superintendent of the district or the principal, assistant principal, or dean of students of any school to suspend students guilty of gross disobedience or misconduct, or to suspend students guilty of gross disobedience or misconduct on the school bus from riding the school bus, pursuant to subsections (b-15) and (b-20) of this Section, and no action shall lie against them for such suspension. The board may by policy authorize the superintendent of the district or the principal, assistant principal, or dean of students of any school to suspend students guilty of such acts for a period not to exceed 10 school days. If a student is suspended due to gross disobedience or misconduct on a school bus, the board may suspend the student in excess of 10 school days for safety reasons.

Any suspension shall be reported immediately to the parents or guardian of a student along with a full statement of the reasons for such suspension and a notice of their right to a review. The school board must be given a summary of the notice, including the reason for the suspension and the suspension length. Upon request of the parents or guardian, the school board or a hearing officer appointed by it shall review such action of the superintendent or principal, assistant principal, or dean of students. At such review, the parents or guardian of the student may appear and discuss the suspension with the board or its hearing officer. If a hearing officer is appointed by the board, he shall report to the board a written summary of the evidence heard at the meeting. After its hearing or upon receipt of the written report of its hearing officer, the board may take such action as it finds appropriate. If a student is suspended pursuant to this subsection (b), the board shall, in the written suspension decision, detail the specific act of gross disobedience or misconduct resulting in the decision to suspend. The suspension decision shall also include a rationale as to the specific duration of the suspension.

(b-5) Among the many possible disciplinary interventions and consequences available to school officials, school exclusions, such as out-of-school suspensions and expulsions, are the most serious. School officials shall limit the number and duration of expulsions and suspensions to the greatest extent practicable, and it is recommended that they use them only for legitimate educational purposes. To ensure that students are not excluded from school unnecessarily, it is recommended that school officials consider forms of non-exclusionary discipline prior to using out-of-school suspensions or expulsions.

(b-10) Unless otherwise required by federal law or this Code, school boards may not institute zero-tolerance policies by which school administrators are required to suspend or expel students for particular behaviors.

(b-15) Out-of-school suspensions of 3 days or less may be used only if the student's continuing presence in school would pose a threat to school safety or a disruption to other students' learning opportunities. For purposes of this subsection (b-15), "threat to school safety or a disruption to other students' learning opportunities" shall be determined on a case-by-case basis by the school board or its designee. School officials shall make all reasonable efforts to resolve such threats, address such disruptions, and minimize the length of suspensions to the greatest extent practicable.

(b-20) Unless otherwise required by this Code, out-of-school suspensions of longer than 3 days, expulsions, and disciplinary removals to alternative schools may be used only if other appropriate and available behavioral and disciplinary interventions have been exhausted and the student's continuing presence in school would either (i) pose a threat to the safety of other students, staff, or members of the school community or (ii) substantially disrupt, impede, or interfere with the operation of the school. For purposes of this subsection (b-20), "threat to the safety of other students, staff, or members of the school community" and "substantially disrupt, impede, or interfere with the operation of the school" shall be determined on a case-by-case basis by school officials. For purposes of this subsection (b-20), the determination of whether "appropriate and available behavioral and disciplinary interventions have been exhausted" shall be made by school officials. School officials shall make all reasonable efforts to resolve

such threats, address such disruptions, and minimize the length of student exclusions to the greatest extent practicable. Within the suspension decision described in subsection (b) of this Section or the expulsion decision described in subsection (a) of this Section, it shall be documented whether other interventions were attempted or whether it was determined that there were no other appropriate and available interventions.

(b-25) Students who are suspended out-of-school for longer than 3 school days shall be provided appropriate and available support services during the period of their suspension. For purposes of this subsection (b-25), "appropriate and available support services" shall be determined by school authorities. Within the suspension decision described in subsection (b) of this Section, it shall be documented whether such services are to be provided or whether it was determined that there are no such appropriate and available services.

A school district may refer students who are expelled to appropriate and available support services.

A school district shall create a policy to facilitate the re-engagement of students who are suspended out-of-school, expelled, or returning from an alternative school setting. In consultation with stakeholders deemed appropriate by the State Board of Education, the State Board of Education shall draft and publish guidance for the re-engagement of students who are suspended out-of-school, expelled, or returning from an alternative school setting in accordance with this Section and Section 13A-4 on or before July 1, 2025.

(b-30) A school district shall create a policy by which suspended students, including those students suspended from the school bus who do not have alternate transportation to school, shall have the opportunity to make up work for equivalent academic credit. It shall be the responsibility of a student's parent or guardian to notify school officials that a student suspended from the school bus does not have alternate transportation to school.

(c) A school board must invite a representative from a local mental health agency to consult with the board at the meeting whenever there is evidence that mental illness may be the cause of a student's expulsion or suspension.

(c-5) School districts shall make reasonable efforts to provide ongoing professional development to all school personnel, school board members, and school resource officers, on the requirements of this Section and Section 10-20.14, the adverse consequences of school exclusion and justice-system involvement, effective classroom management strategies, culturally responsive discipline, trauma-responsive learning environments, as defined in subsection (b) of Section 3-11, the appropriate and available supportive services for the promotion of student attendance and engagement, and developmentally appropriate disciplinary methods that promote positive and healthy school climates.

(d) The board may expel a student for a definite period of time not to exceed 2 calendar years, as determined on a case-by-case basis. A student who is determined to have brought one of the following objects to school, any school-sponsored activity or event, or any activity or event that bears a reasonable relationship to school shall be expelled for a period of not less than one year:

(1) A firearm. For the purposes of this Section, "firearm" means any gun, rifle, shotgun, weapon as defined by Section 921 of Title 18 of the United States Code, firearm as defined in Section 1.1 of the Firearm Owners Identification Card Act, or firearm as defined in Section 24-1 of the Criminal Code of 2012. The expulsion period under this subdivision (1) may be modified by the superintendent, and the superintendent's determination may be modified by the board on a case-by-case basis.

(2) A knife, brass knuckles or other knuckle weapon regardless of its composition, a billy club, or any other object if used or attempted to be used to cause bodily harm, including "look alikes" of any firearm as defined in subdivision (1) of this subsection (d). The expulsion requirement under this subdivision (2) may be modified by the superintendent, and the superintendent's determination may be modified by the board on a case-by-case basis.

Expulsion or suspension shall be construed in a manner consistent with the federal Individuals with Disabilities Education Act. A student who is subject to suspension or expulsion as provided in this Section may be eligible for a transfer to an alternative school program in accordance with Article 13A of the School Code.

(d-5) The board may suspend or by regulation authorize the superintendent of the district or the principal, assistant principal, or dean of students of any school to suspend a student for a period not to exceed 10 school days or may expel a student for a definite period of time not to exceed 2 calendar years, as determined on a case-by-case basis, if (i) that student has been determined to have made an explicit threat on an Internet website against a school employee, a student, or any school-related personnel, (ii) the Internet website through which the threat was made is a site that was accessible within the school at the time the

threat was made or was available to third parties who worked or studied within the school grounds at the time the threat was made, and (iii) the threat could be reasonably interpreted as threatening to the safety and security of the threatened individual because of the individual's duties or employment status or status as a student inside the school.

(e) To maintain order and security in the schools, school authorities may inspect and search places and areas such as lockers, desks, parking lots, and other school property and equipment owned or controlled by the school, as well as personal effects left in those places and areas by students, without notice to or the consent of the student, and without a search warrant. As a matter of public policy, the General Assembly finds that students have no reasonable expectation of privacy in these places and areas or in their personal effects left in these places and areas. School authorities may request the assistance of law enforcement officials for the purpose of conducting inspections and searches of lockers, desks, parking lots, and other school property and equipment owned or controlled by the school for illegal drugs, weapons, or other illegal or dangerous substances or materials, including searches conducted through the use of specially trained dogs. If a search conducted in accordance with this Section produces evidence that the student has violated or is violating either the law, local ordinance, or the school's policies or rules, such evidence may be seized by school authorities, and disciplinary action may be taken. School authorities may also turn over such evidence to law enforcement authorities.

(f) Suspension or expulsion may include suspension or expulsion from school and all school activities and a prohibition from being present on school grounds.

(g) A school district may adopt a policy providing that if a student is suspended or expelled for any reason from any public or private school in this or any other state, the student must complete the entire term of the suspension or expulsion in an alternative school program under Article 13A of this Code or an alternative learning opportunities program under Article 13B of this Code before being admitted into the school district if there is no threat to the safety of students or staff in the alternative program.

(h) School officials shall not advise or encourage students to drop out voluntarily due to behavioral or academic difficulties.

(i) A student may not be issued a monetary fine or fee as a disciplinary consequence, though this shall not preclude requiring a student to provide restitution for lost, stolen, or damaged property.

(j) Subsections (a) through (i) of this Section shall apply to elementary and secondary schools, charter schools, special charter districts, and school districts organized under Article 34 of this Code.

(k) The expulsion of students enrolled in programs funded under Section 1C-2 of this Code is subject to the requirements under paragraph (7) of subsection (a) of Section 2-3.71 of this Code.

(l) An in-school suspension program provided by a school district for any students in kindergarten through grade 12 may focus on promoting non-violent conflict resolution and positive interaction with other students and school personnel. A school district may employ a school social worker or a licensed mental health professional to oversee an in-school suspension program in kindergarten through grade 12.

(Source: P.A. 102-539, eff. 8-20-21; 102-813, eff. 5-13-22; 103-594, eff. 6-25-24; 103-896, eff. 8-9-24; revised 9-25-24.)

(Text of Section after amendment by P.A. 102-466)

Sec. 10-22.6. Suspension or expulsion of students; school searches.

(a) To expel students in grades 3 through 12 guilty of gross disobedience or misconduct, including gross disobedience or misconduct perpetuated by electronic means, pursuant to subsection (b-20) of this Section, and no action shall lie against them for such expulsion. Unless otherwise required by subsection (d), in no case may a school board expel a student in kindergarten through grade 2. No action may be brought against the school board for an expulsion in kindergarten through grade 2 pursuant to subsection (d). Subject to this grade-level restriction, ~~expulsion~~ Expulsion shall take place only after the parents or guardians have been requested to appear at a meeting of the board, or with a hearing officer appointed by it, to discuss their child's behavior. Such request shall be made by registered or certified mail and shall state the time, place and purpose of the meeting. The board, or a hearing officer appointed by it, at such meeting shall state the reasons for dismissal and the date on which the expulsion is to become effective. If a hearing officer is appointed by the board, the hearing officer shall report to the board a written summary of the evidence heard at the meeting and the board may take such action thereon as it finds appropriate. If the board acts to expel a student, the written expulsion decision shall detail the specific reasons why removing the student from the learning environment is in the best interest of the school. The expulsion decision shall also include a rationale as to the specific duration of the expulsion. An expelled student may be immediately

transferred to an alternative program in the manner provided in Article 13A or 13B of this Code. A student must not be denied transfer because of the expulsion, except in cases in which such transfer is deemed to cause a threat to the safety of students or staff in the alternative program.

(b) To suspend or by policy to authorize the superintendent of the district or the principal, assistant principal, or dean of students of any school to suspend students guilty of gross disobedience or misconduct, or to suspend students guilty of gross disobedience or misconduct on the school bus from riding the school bus, pursuant to subsections (b-15) and (b-20) of this Section, and no action shall lie against them for such suspension. The board may by policy authorize the superintendent of the district or the principal, assistant principal, or dean of students of any school to suspend students guilty of such acts for a period not to exceed 10 school days. If a student is suspended due to gross disobedience or misconduct on a school bus, the board may suspend the student in excess of 10 school days for safety reasons. The superintendent of the school district shall be required to provide verbal or written approval to suspend a student in kindergarten through grade 2 for longer than 3 school days. If superintendent approval is not received by the third day, the student shall return to school by the fourth day. The length of the suspension for any student in kindergarten through grade 2 may not be for longer than the number of days required by the district to develop and implement a behavior intervention plan or safety plan.

Any suspension shall be reported immediately to the parents or guardians of a student along with a full statement of the reasons for such suspension and a notice of their right to a review. The school board must be given a summary of the notice, including the reason for the suspension and the suspension length. Upon request of the parents or guardians, the school board or a hearing officer appointed by it shall review such action of the superintendent or principal, assistant principal, or dean of students. At such review, the parents or guardians of the student may appear and discuss the suspension with the board or its hearing officer. If a hearing officer is appointed by the board, he shall report to the board a written summary of the evidence heard at the meeting. After its hearing or upon receipt of the written report of its hearing officer, the board may take such action as it finds appropriate. If a student is suspended pursuant to this subsection (b), the board shall, in the written suspension decision, detail the specific act of gross disobedience or misconduct resulting in the decision to suspend. The suspension decision shall also include a rationale as to the specific duration of the suspension.

(b-5) Among the many possible disciplinary interventions and consequences available to school officials, school exclusions, such as out-of-school suspensions and expulsions, are the most serious. School officials shall limit the number and duration of expulsions and suspensions to the greatest extent practicable, and it is recommended that they use them only for legitimate educational purposes. To ensure that students are not excluded from school unnecessarily, it is recommended that school officials consider forms of non-exclusionary discipline prior to using out-of-school suspensions or expulsions.

(b-10) Unless otherwise required by subsection (d) federal law or this Code, school boards may not institute zero-tolerance policies by which school administrators are required to suspend or expel students for particular behaviors.

(b-15) Out-of-school suspensions of 3 days or less may be used only if the student's continuing presence in school would pose a threat to school safety or a disruption to other students' learning opportunities. For purposes of this subsection (b-15), "threat to school safety or a disruption to other students' learning opportunities" shall be determined on a case-by-case basis by the school board or its designee. School officials shall make all reasonable efforts to resolve such threats, address such disruptions, and minimize the length of suspensions to the greatest extent practicable.

(b-20) Unless otherwise required by this Code, out-of-school suspensions of longer than 3 days, expulsions for students in grades 3 through 12 or, if required by subsection (d), expulsions for students in kindergarten through grade 2, and disciplinary removals to alternative schools for students who meet the grade-level restrictions set forth in Articles 13A and 13B may be used only if other appropriate and available behavioral and disciplinary interventions have been exhausted and the student's continuing presence in school would either (i) pose a threat to the safety of other students, staff, or members of the school community or (ii) substantially disrupt, impede, or interfere with the operation of the school. For purposes of this subsection (b-20), "threat to the safety of other students, staff, or members of the school community" and "substantially disrupt, impede, or interfere with the operation of the school" shall be determined on a case-by-case basis by school officials. For purposes of this subsection (b-20), the determination of whether "appropriate and available behavioral and disciplinary interventions have been exhausted" shall be made by school officials. School officials shall make all reasonable efforts to resolve such threats, address such disruptions, and minimize the length of student exclusions to the greatest extent

practicable. Within the suspension decision described in subsection (b) of this Section or the expulsion decision described in subsection (a) of this Section, it shall be documented whether other interventions were attempted or whether it was determined that there were no other appropriate and available interventions.

(b-25) Students who are suspended out-of-school for longer than 3 school days shall be provided appropriate and available support services during the period of their suspension. For purposes of this subsection (b-25), "appropriate and available support services" shall be determined by school authorities. Within the suspension decision described in subsection (b) of this Section, it shall be documented whether such services are to be provided or whether it was determined that there are no such appropriate and available services. The superintendent of the school district shall be required to provide verbal or written approval to suspend a student in kindergarten through grade 2 for longer than 3 school days. If superintendent approval is not received by the third day, the student shall return to school by the fourth day.

A school district may refer students who are expelled to appropriate and available support services.

A school district shall create a policy to facilitate the re-engagement of students who are suspended out-of-school, expelled, or returning from an alternative school setting. In consultation with stakeholders deemed appropriate by the State Board of Education, the State Board of Education shall draft and publish guidance for the re-engagement of students who are suspended out-of-school, expelled, or returning from an alternative school setting in accordance with this Section and Section 13A-4 on or before July 1, 2025.

(b-30) A school district shall create a policy by which suspended students, including those students suspended from the school bus who do not have alternate transportation to school, shall have the opportunity to make up work for equivalent academic credit. It shall be the responsibility of a student's parents or guardians to notify school officials that a student suspended from the school bus does not have alternate transportation to school.

(b-35) In all suspension review hearings conducted under subsection (b) or expulsion hearings conducted under subsection (a), a student may disclose any factor to be considered in mitigation, including his or her status as a parent, expectant parent, or victim of domestic or sexual violence, as defined in Article 26A. A representative of the parent's or guardian's choice, or of the student's choice if emancipated, must be permitted to represent the student throughout the proceedings and to address the school board or its appointed hearing officer. With the approval of the student's parent or guardian, or of the student if emancipated, a support person must be permitted to accompany the student to any disciplinary hearings or proceedings. The representative or support person must comply with any rules of the school district's hearing process. If the representative or support person violates the rules or engages in behavior or advocacy that harasses, abuses, or intimidates either party, a witness, or anyone else in attendance at the hearing, the representative or support person may be prohibited from further participation in the hearing or proceeding. A suspension or expulsion proceeding under this subsection (b-35) must be conducted independently from any ongoing criminal investigation or proceeding, and an absence of pending or possible criminal charges, criminal investigations, or proceedings may not be a factor in school disciplinary decisions.

(b-40) During a suspension review hearing conducted under subsection (b) or an expulsion hearing conducted under subsection (a) that involves allegations of sexual violence by the student who is subject to discipline, neither the student nor his or her representative shall directly question nor have direct contact with the alleged victim. The student who is subject to discipline or his or her representative may, at the discretion and direction of the school board or its appointed hearing officer, suggest questions to be posed by the school board or its appointed hearing officer to the alleged victim.

(c) A school board must invite a representative from a local mental health agency to consult with the board at the meeting whenever there is evidence that mental illness may be the cause of a student's expulsion or suspension.

(c-5) School districts shall make reasonable efforts to provide ongoing professional development to all school personnel, school board members, and school resource officers on the requirements of this Section and Section 10-20.14, the adverse consequences of school exclusion and justice-system involvement, effective classroom management strategies, culturally responsive discipline, trauma-responsive learning environments, as defined in subsection (b) of Section 3-11, the appropriate and available supportive services for the promotion of student attendance and engagement, and developmentally appropriate disciplinary methods that promote positive and healthy school climates.

(d) The board may expel a student in grades 3 through 12 for a definite period of time not to exceed 2 calendar years, as determined on a case-by-case basis. In no case may a student expelled under this Section be expelled for a period exceeding 2 calendar years. A student in kindergarten through grade 12 who is determined to have brought or possessed one of the following objects to or at school, any school-sponsored

activity or event, or any activity or event that bears a reasonable relationship to school shall be expelled for a period of not less than one year:

(1) A firearm. For the purposes of this Section, "firearm" means any gun, rifle, shotgun, weapon as defined by Section 921 of Title 18 of the United States Code, firearm as defined in Section 1.1 of the Firearm Owners Identification Card Act, or firearm as defined in Section 24-1 of the Criminal Code of 2012. The expulsion requirement period under this subdivision (1) may be modified by the superintendent if such modification is in writing, and the superintendent's determination may be modified by the board on a case-by-case basis if such modification is in writing.

(2) A knife, brass knuckles or other knuckle weapon regardless of its composition, a billy club, or any other object if used or attempted to be used to cause bodily harm, including "look alikes" of any firearm as defined in subdivision (1) of this subsection (d). For purposes of this subdivision (2), "bodily harm" means an injury that involves a substantial risk of death, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member or organ. The expulsion requirement under this subdivision (2) may be modified by the superintendent, and the superintendent's determination may be modified by the board on a case-by-case basis. The board may not expel a student in kindergarten through grade 2 under this subdivision (2) unless the student is determined to have brought or possessed the object with the intent to cause bodily harm.

Expulsion or suspension shall be construed in a manner consistent with the federal Individuals with Disabilities Education Act. A student who is subject to suspension or expulsion as provided in this Section may be eligible for a transfer to an alternative school program in accordance with Article 13A of the School Code.

(d-5) The board, for a student in grades 3 through 12, may suspend or, by regulation, authorize the superintendent of the district or the principal, assistant principal, or dean of students of any school to suspend or, for a student in kindergarten through grade 2, may suspend or, by regulation, authorize the superintendent of the district to suspend a student for a period not to exceed 10 school days or may expel a student in grades 3 through 12 or, if required by subsection (d), a student in kindergarten through grade 2 for a definite period of time not to exceed 2 calendar years, as determined on a case-by-case basis, if (i) that student has been determined to have made an explicit threat on an Internet website against a school employee, a student, or any school-related personnel, (ii) the Internet website through which the threat was made is a site that was accessible within the school at the time the threat was made or was available to third parties who worked or studied within the school grounds at the time the threat was made, and (iii) the threat could be reasonably interpreted as threatening to the safety and security of the threatened individual because of the individual's duties or employment status or status as a student inside the school.

(e) To maintain order and security in the schools, school authorities may inspect and search places and areas such as lockers, desks, parking lots, and other school property and equipment owned or controlled by the school, as well as personal effects left in those places and areas by students, without notice to or the consent of the student, and without a search warrant. As a matter of public policy, the General Assembly finds that students have no reasonable expectation of privacy in these places and areas or in their personal effects left in these places and areas. School authorities may request the assistance of law enforcement officials for the purpose of conducting inspections and searches of lockers, desks, parking lots, and other school property and equipment owned or controlled by the school for illegal drugs, weapons, or other illegal or dangerous substances or materials, including searches conducted through the use of specially trained dogs. If a search conducted in accordance with this Section produces evidence that the student has violated or is violating either the law, local ordinance, or the school's policies or rules, such evidence may be seized by school authorities, and disciplinary action may be taken. School authorities may also turn over such evidence to law enforcement authorities.

(f) Suspension or expulsion may include suspension or expulsion from school and all school activities and a prohibition from being present on school grounds.

(g) A school district may adopt a policy providing that if a student is suspended or expelled for any reason from any public or private school in this or any other state, the student must complete the entire term of the suspension or expulsion in an alternative school program under Article 13A of this Code or an alternative learning opportunities program under Article 13B of this Code before being admitted into the school district if there is no threat to the safety of students or staff in the alternative program. A school district that adopts a policy under this subsection (g) must include a provision allowing for consideration of any mitigating factors, including, but not limited to, a student's status as a parent, expectant parent, or victim of domestic or sexual violence, as defined in Article 26A.

(h) School officials shall not advise or encourage students to drop out voluntarily due to behavioral or academic difficulties.

(i) A student may not be issued a monetary fine or fee as a disciplinary consequence, though this shall not preclude requiring a student to provide restitution for lost, stolen, or damaged property.

(j) Subsections (a) through (i) of this Section shall apply to elementary and secondary schools, charter schools, special charter districts, and school districts organized under Article 34 of this Code.

(k) Through June 30, 2026, the expulsion of students enrolled in programs funded under Section 1C-2 of this Code is subject to the requirements under paragraph (7) of subsection (a) of Section 2-3.71 of this Code.

(k-5) On and after July 1, 2026, the expulsion of children enrolled in programs funded under Section 15-25 of the Department of Early Childhood Act is subject to the requirements of paragraph (7) of subsection (a) of Section 15-30 of the Department of Early Childhood Act. The suspension of students enrolled in programs funded under Section 15-25 of the Department of Early Childhood Act is subject to the requirements of paragraph (8) of subsection (a) of Section 15-30 of the Department of Early Childhood Act.

(l) An in-school suspension program provided by a school district for any students in kindergarten through grade 12 may focus on promoting non-violent conflict resolution and positive interaction with other students and school personnel. A school district may employ a school social worker or a licensed mental health professional to oversee an in-school suspension program in kindergarten through grade 12.

(Source: P.A. 102-466, eff. 7-1-25; 102-539, eff. 8-20-21; 102-813, eff. 5-13-22; 103-594, eff. 6-25-24; 103-896, eff. 8-9-24; revised 9-25-24.)

(105 ILCS 5/13B-20.25)

Sec. 13B-20.25. Eligible students. Students in kindergarten grades 4 through grade 12 who meet enrollment criteria established by the school district and who meet the definition of "student at risk of academic failure" are eligible to participate in an alternative learning opportunities program funded under this Article. Notwithstanding any other provision of law to the contrary, enrollment in a charter alternative learning opportunities program shall be open to any student pupil who has been expelled or suspended ~~for more than 20 days~~ under Section 10-22.6 or 34-19 of this Code. Any student in kindergarten through grade 2 placed in an out-of-district alternative learning opportunities program shall have the student's placement limited to 90 days beginning on the student's first date of attendance in the program. For students with disabilities, such removal shall be consistent with 34 CFR 300.530.

All rights granted under this Article to a student's parent or guardian become exclusively those of the student upon the student's 18th birthday.

The State Board of Education may adopt rules to clarify the implementation of this Section.

(Source: P.A. 97-495, eff. 1-1-12.)

(105 ILCS 5/13B-20.30)

Sec. 13B-20.30. Location of program. A school district must consider offering an alternative learning opportunities program on-site in the regular school. An alternative learning opportunities program may be provided at facilities separate from the regular school or in classrooms elsewhere on school premises; however, in no instance may a student in kindergarten through grade 5 who is enrolled in an alternative learning opportunities program participate in that program or receive services outside of the student's home district except as otherwise provided in this Section. A district is encouraged to ensure that educational support and other services are provided to the student as part of the student's activities in the classroom to which the student is originally assigned, unless the nature of the services dictate otherwise. Any student in kindergarten through grade 2 placed in an out-of-district alternative learning opportunities program shall have the student's placement limited to 90 days beginning on the student's first date of attendance in the program. For students with disabilities, such removal shall be consistent with 34 CFR 300.530.

The State Board of Education may adopt rules to clarify the implementation of this Section.

(Source: P.A. 92-42, eff. 1-1-02.)

(105 ILCS 5/13B-25.5)

Sec. 13B-25.5. General standards for eligibility for funding. To be eligible for funding, an alternative learning opportunities program must provide evidence of an administrative structure, program activities, program staff, a budget, and a specific curriculum that is consistent with Illinois Learning Standards but may be different from the regular school program in terms of location, subject to the limitations set forth in Section 13B-20.30 of this Code, length of school day, program sequence, pace, instructional activities, or any combination of these.

(Source: P.A. 92-42, eff. 1-1-02.)

Section 10. The Department of Early Childhood Act is amended by changing Section 15-30 as follows:

(325 ILCS 3/15-30)

Sec. 15-30. Grants for preschool educational programs.

(a) Preschool program.

(1) Through June 30, 2026, The State Board of Education shall implement and administer a grant program to conduct voluntary preschool educational programs for children ages 3 to 5, which include a parent education component, pursuant to Section 2-3.71 of the School Code.

(2) On and after July 1, 2026, the Department of Early Childhood shall implement and administer a grant program for school districts and other eligible entities, as defined by the Department, to conduct voluntary preschool educational programs for children ages 3 to 5 which include a parent education component. A public school district which receives grants under this subsection may subcontract with other entities that are eligible to conduct a preschool educational program. These grants must be used to supplement, not supplant, funds received from any other source.

(3) Except as otherwise provided under this subsection (a), any teacher of preschool children in the program authorized by this subsection shall hold a Professional Educator License with an early childhood education endorsement.

(3.5) Beginning with the 2018-2019 school year and until the 2028-2029 school year, an individual may teach preschool children in an early childhood program under this Section if he or she holds a Professional Educator License with an early childhood education endorsement or with short-term approval for early childhood education or he or she pursues a Professional Educator License and holds any of the following:

(A) An ECE Credential Level of 5 awarded by the Department of Human Services under the Gateways to Opportunity Program developed under Section 10-70 of the Department of Human Services Act.

(B) An Educator License with Stipulations with a transitional bilingual educator endorsement and he or she has (i) passed an early childhood education content test or (ii) completed no less than 9 semester hours of postsecondary coursework in the area of early childhood education.

(4) Through June 30, 2026, the State Board of Education shall provide the primary source of funding through appropriations for the program. On and after July 1, 2026, the Department of Early Childhood shall provide the primary source of funding through appropriations for the program. Such funds shall be distributed to achieve a goal of "Preschool for All Children" for the benefit of all children whose families choose to participate in the program. Based on available appropriations, newly funded programs shall be selected through a process giving first priority to qualified programs serving primarily at-risk children and second priority to qualified programs serving primarily children with a family income of less than 4 times the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). For purposes of this paragraph (4), at-risk children are those who because of their home and community environment are subject to such language, cultural, economic and like disadvantages to cause them to have been determined as a result of screening procedures to be at risk of academic failure. Through June 30, 2026, such screening procedures shall be based on criteria established by the State Board of Education. On and after July 1, 2026, such screening procedures shall be based on criteria established by the Department of Early Childhood. Except as otherwise provided in this paragraph (4), grantees under the program must enter into a memorandum of understanding with the appropriate local Head Start agency. This memorandum must be entered into no later than 3 months after the award of a grantee's grant under the program and must address collaboration between the grantee's program and the local Head Start agency on certain issues, which shall include without limitation the following:

(A) educational activities, curricular objectives, and instruction;

(B) public information dissemination and access to programs for families contacting programs;

(C) service areas;

(D) selection priorities for eligible children to be served by programs;

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- (E) maximizing the impact of federal and State funding to benefit young children;
- (F) staff training, including opportunities for joint staff training;
- (G) technical assistance;
- (H) communication and parent outreach for smooth transitions to kindergarten;
- (I) provision and use of facilities, transportation, and other program elements;
- (J) facilitating each program's fulfillment of its statutory and regulatory requirements;
- (K) improving local planning and collaboration; and
- (L) providing comprehensive services for the neediest Illinois children and families.

Through June 30, 2026, if the appropriate local Head Start agency is unable or unwilling to enter into a memorandum of understanding as required under this paragraph (4), the memorandum of understanding requirement shall not apply and the grantee under the program must notify the State Board of Education in writing of the Head Start agency's inability or unwillingness. Through June 30, 2026, the State Board of Education shall compile all such written notices and make them available to the public. On and after July 1, 2026, if the appropriate local Head Start agency is unable or unwilling to enter into a memorandum of understanding as required under this paragraph (4), the memorandum of understanding requirement shall not apply and the grantee under the program must notify the Department of Early Childhood in writing of the Head Start agency's inability or unwillingness. The Department of Early Childhood shall compile all such written notices and make them available to the public.

(5) Through June 30, 2026, the State Board of Education shall develop and provide evaluation tools, including tests, that school districts and other eligible entities may use to evaluate children for school readiness prior to age 5. The State Board of Education shall require school districts and other eligible entities to obtain consent from the parents or guardians of children before any evaluations are conducted. The State Board of Education shall encourage local school districts and other eligible entities to evaluate the population of preschool children in their communities and provide preschool programs, pursuant to this subsection, where appropriate.

(5.1) On and after July 1, 2026, the Department of Early Childhood shall develop and provide evaluation tools, including tests, that school districts and other eligible entities may use to evaluate children for school readiness prior to age 5. The Department of Early Childhood shall require school districts and other eligible entities to obtain consent from the parents or guardians of children before any evaluations are conducted. The Department of Early Childhood shall encourage local school districts and other eligible entities to evaluate the population of preschool children in their communities and provide preschool programs, pursuant to this subsection, where appropriate.

(6) Through June 30, 2026, the State Board of Education shall report to the General Assembly by November 1, 2018 and every 2 years thereafter on the results and progress of students who were enrolled in preschool educational programs, including an assessment of which programs have been most successful in promoting academic excellence and alleviating academic failure. Through June 30, 2026, the State Board of Education shall assess the academic progress of all students who have been enrolled in preschool educational programs. Through Fiscal Year 2026, on or before November 1 of each fiscal year in which the General Assembly provides funding for new programs under paragraph (4) of this Section, the State Board of Education shall report to the General Assembly on what percentage of new funding was provided to programs serving primarily at-risk children, what percentage of new funding was provided to programs serving primarily children with a family income of less than 4 times the federal poverty level, and what percentage of new funding was provided to other programs.

(6.1) On and after July 1, 2026, the Department of Early Childhood shall report to the General Assembly by November 1, 2026 and every 2 years thereafter on the results and progress of students who were enrolled in preschool educational programs, including an assessment of which programs have been most successful in promoting academic excellence and alleviating academic failure. On and after July 1, 2026, the Department of Early Childhood shall assess the academic progress of all students who have been enrolled in preschool educational programs. Beginning in Fiscal Year 2027, on or before November 1 of each fiscal year in which the General Assembly provides funding for new programs under paragraph (4) of this Section, the Department of Early Childhood shall report to the General Assembly on what percentage of new funding was provided to programs serving primarily at-risk children, what percentage of new funding was provided to programs serving primarily children

with a family income of less than 4 times the federal poverty level, and what percentage of new funding was provided to other programs.

(7) Due to evidence that expulsion practices in the preschool years are linked to poor child outcomes and are employed inconsistently across racial and gender groups, early childhood programs receiving State funds under this subsection (a) shall prohibit expulsions. Planned transitions to settings that are able to better meet a child's needs are not considered expulsion under this paragraph (7).

(A) When persistent and serious challenging behaviors emerge, the early childhood program shall document steps taken to ensure that the child can participate safely in the program; including observations of initial and ongoing challenging behaviors, strategies for remediation and intervention plans to address the behaviors, and communication with the parent or legal guardian, including participation of the parent or legal guardian in planning and decision-making.

(B) The early childhood program shall, with parental or legal guardian consent as required, use a range of community resources, if available and deemed necessary, including, but not limited to, developmental screenings, referrals to programs and services administered by a local educational agency or early intervention agency under Parts B and C of the federal Individual with Disabilities Education Act, and consultation with infant and early childhood mental health consultants and the child's health care provider. The program shall document attempts to engage these resources, including parent or legal guardian participation and consent attempted and obtained. Communication with the parent or legal guardian shall take place in a culturally and linguistically competent manner.

(C) If there is documented evidence that all available interventions and supports recommended by a qualified professional have been exhausted and the program determines in its professional judgment that transitioning a child to another program is necessary for the well-being of the child or his or her peers and staff, with parent or legal guardian permission, both the current and pending programs shall create a transition plan designed to ensure continuity of services and the comprehensive development of the child. Communication with families shall occur in a culturally and linguistically competent manner.

(D) Nothing in this paragraph (7) shall preclude a parent's or legal guardian's right to voluntarily withdraw his or her child from an early childhood program. Early childhood programs shall request and keep on file, when received, a written statement from the parent or legal guardian stating the reason for his or her decision to withdraw his or her child.

(E) In the case of the determination of a serious safety threat to a child or others or in the case of behaviors listed in subsection (d) of Section 10-22.6 of the School Code, the temporary removal of a child from attendance in group settings may be used. Temporary removal of a child from attendance in a group setting shall trigger the process detailed in subparagraphs (A), (B), and (C) of this paragraph (7), with the child placed back in a group setting as quickly as possible.

(F) Early childhood programs may use and the Department of Early Childhood, State Board of Education, the Department of Human Services, and the Department of Children and Family Services shall recommend training, technical support, and professional development resources to improve the ability of teachers, administrators, program directors, and other staff to promote social-emotional development and behavioral health, to address challenging behaviors, and to understand trauma and trauma-informed care, cultural competence, family engagement with diverse populations, the impact of implicit bias on adult behavior, and the use of reflective practice techniques. Support shall include the availability of resources to contract with infant and early childhood mental health consultants.

(G) Through June 30, 2026, early childhood programs shall annually report to the State Board of Education, and, beginning in Fiscal Year 2020, the State Board of Education shall make available on a biennial basis, in an existing report, all of the following data for children from birth to age 5 who are served by the program:

(i) Total number served over the course of the program year and the total number of children who left the program during the program year.

(ii) Number of planned transitions to another program due to children's behavior, by children's race, gender, disability, language, class/group size, teacher-child ratio, and length of program day.

(iii) Number of temporary removals of a child from attendance in group settings due to a serious safety threat under subparagraph (E) of this paragraph (7), by children's race, gender, disability, language, class/group size, teacher-child ratio, and length of program day.

(iv) Hours of infant and early childhood mental health consultant contact with program leaders, staff, and families over the program year.

(G-5) On and after July 1, 2026, early childhood programs shall annually report to the Department of Early Childhood, and beginning in Fiscal Year 2028, the Department of Early Childhood shall make available on a biennial basis, in a report, all of the following data for children from birth to age 5 who are served by the program:

(i) Total number served over the course of the program year and the total number of children who left the program during the program year.

(ii) Number of planned transitions to another program due to children's behavior, by children's race, gender, disability, language, class/group size, teacher-child ratio, and length of program day.

(iii) Number of temporary removals of a child from attendance in group settings due to a serious safety threat under subparagraph (E) of this paragraph (7), by children's race, gender, disability, language, class/group size, teacher-child ratio, and length of program day.

(iv) Hours of infant and early childhood mental health consultant contact with program leaders, staff, and families over the program year.

(H) Changes to services for children with an individualized education program or individual family service plan shall be construed in a manner consistent with the federal Individuals with Disabilities Education Act.

The Department of Early Childhood, in consultation with the Department of Children and Family Services, shall adopt rules to administer this paragraph (7).

(8) Due to evidence that suspension practices in the preschool years are linked to poor child outcomes and are employed inconsistently across racial and gender groups, early childhood programs that receive State funds under this subsection (a) shall restrict suspensions. Planned transitions to settings that are able to better meet a child's needs are not considered a suspension for purposes of this paragraph (8). The superintendent of a school district, the director of an early childhood program, or the superintendent's or director's equivalent shall be required to provide verbal or written approval to suspend a student in preschool for longer than 3 days. If such approval is not received by the third day, the student shall return to school by the fourth day. The length of the suspension for any student in preschool may not be for longer than the number of days required by the school district or early childhood program to develop and implement a behavior intervention plan or safety plan.

(b) Notwithstanding any other provisions of this Section, grantees may serve children ages 0 to 12 of essential workers if the Governor has declared a disaster due to a public health emergency pursuant to Section 7 of the Illinois Emergency Management Agency Act. The Department of Early Childhood may adopt rules to administer this subsection.

(Source: P.A. 103-594, eff. 6-25-24.)

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

Section 99. Effective date. This Act takes effect upon becoming law, except that the provisions changing Section 10-22.6 of the School Code and Section 15-30 of the Department of Early Childhood Act take effect July 1, 2027."

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Castro, **House Bill No. 1821** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Castro, **House Bill No. 2690** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Criminal Law, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 2690

AMENDMENT NO. 1. Amend House Bill 2690 on page 31, line 21, by replacing "or" with "or"; and

on page 77, line 12, by replacing "pornography" with "sexual abuse material pornography"; and

on page 77, line 17, by replacing "pornography" with "sexual abuse material pornography".

There being no further amendments, the bill, as amended, was ordered to a third reading.

SENATE BILL RECALLED

On motion of Senator Belt, **Senate Bill No. 314** was recalled from the order of third reading to the order of second reading.

Senator Belt offered the following amendment and moved its adoption:

AMENDMENT NO. 1 TO SENATE BILL 314

AMENDMENT NO. 1. Amend Senate Bill 314 by replacing everything after the enacting clause with the following:

"Section 5. The Physical Fitness Services Act is amended by adding Section 7.5 as follows:
(815 ILCS 645/7.5 new)

Sec. 7.5. Contract requirements; lifetime memberships.

(a) As used in this Section, "lifetime membership contract" means a membership contract advertised or represented by a physical fitness center as a membership to that physical fitness center for the duration of the life of the customer.

(b) A physical fitness center that offers a lifetime membership contract shall honor the terms of the lifetime membership contract, including all costs charged to the customer, for the duration of the life of the customer. A physical fitness center shall not increase any costs or fees or diminish any benefits provided for in the lifetime membership contract unless: (i) the physical fitness center is sold to a person or entity that is not affiliated with or controlled by the original person or entity who operated the physical fitness center that entered into the lifetime membership contract with the customer; or (ii) the customer voluntarily agrees in writing to change the terms of the lifetime membership contract.

(c) Any lifetime membership contract that includes provisions that allow for increases in costs or fees or reductions in benefits shall disclose the provisions in a bold, clearly readable font that is consistent with the typeface used in the contract.

(d) A physical fitness center shall provide a copy of the lifetime membership contract to the customer upon the request of the customer."

The motion prevailed.

And the amendment was adopted and ordered printed.

Senator Belt offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO SENATE BILL 314

AMENDMENT NO. 2. Amend Senate Bill 314 by replacing everything after the enacting clause with the following:

"Section 5. The Physical Fitness Services Act is amended by adding Section 7.5 as follows:

(815 ILCS 645/7.5 new)

Sec. 7.5. Contract requirements; lifetime memberships.

(a) As used in this Section, "lifetime membership" means a membership advertised or represented by a physical fitness center as a membership to that physical fitness center that lasts for the duration of the life of the customer unless cancelled by the customer.

(b) A physical fitness center that offers a lifetime membership that includes provisions in the membership contract that allow for increases in costs or fees or reductions in benefits shall disclose those provisions clearly and conspicuously in a bold, clearly readable font that is consistent with the typeface used in the contract.

(c) If a physical fitness center that offers a lifetime membership fails to clearly and conspicuously disclose that the lifetime membership's costs or fees could increase or the lifetime membership's benefits could be reduced, as described in subsection (b), either during the contract's initial term of services or with respect to any automatic renewal of the contract, then the physical fitness center must honor the original terms of the membership for the duration of the life of the customer and shall not increase any costs or fees or reduce any benefits provided for in the original lifetime membership unless: (i) the physical fitness center is sold to a person or entity that is not affiliated with or controlled by the original person or entity who operated the physical fitness center that entered into the lifetime membership contract with the customer; or (ii) the customer voluntarily agrees in writing to change the terms of the lifetime membership.

(d) A physical fitness center shall provide a copy of the lifetime membership contract to the customer upon the request of the customer."

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendments numbered 1 and 2 were ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Belt, **Senate Bill No. 314** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 51; NAYS 4.

The following voted in the affirmative:

Anderson	Faraci	Jones, E.	Simmons
Aquino	Feigenholtz	Koehler	Sims
Arellano, L.	Fine	Lewis	Stadelman
Balkema	Fowler	Lightford	Syverson
Belt	Glowiak Hilton	Loughran Cappel	Tracy
Castro	Guzmán	McClure	Turner, S.
Cervantes	Halpin	Morrison	Ventura
Collins	Harris, N.	Murphy	Villa
Cunningham	Harriss, E.	Peters	Villanueva
Curran	Hastings	Porfirio	Villivalam
DeWitte	Hills	Preston	Walker
Edly-Allen	Holmes	Rezin	Mr. President
Ellman	Johnson	Rose	

[May 8, 2025]

The following voted in the negative:

Bryant	Plummer
Chesney	Wilcox

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Aquino, **Senate Bill No. 406** was recalled from the order of third reading to the order of second reading.

Senator Aquino offered the following amendment and moved its adoption:

AMENDMENT NO. 1 TO SENATE BILL 406

AMENDMENT NO. 1. Amend Senate Bill 406 by replacing everything after the enacting clause with the following:

"Section 5. The Department of Early Childhood Act is amended by changing Section 1-30 as follows:
(325 ILCS 3/1-30)

Sec. 1-30. General powers and duties.

(a) The Department shall exercise the rights, powers, duties, and functions provided by law, including, but not limited to, the rights, powers, duties, and functions transferred to the Department.

(a-5) The Department shall establish an Early Childhood Integrated Data System (ECIDS) to make equity driven, inclusive, and data-informed decisions that create a simpler, better, and fairer system for all Illinois children and families.

The Department shall develop public analytic portals and query tools for parents and communities to access aggregated integrated data from the ECIDS system to the extent permitted by State and federal confidentiality requirements.

(b) The Department may employ personnel (in accordance with the Personnel Code and any applicable collective bargaining agreements), provide facilities, contract for goods and services, and adopt rules as necessary to carry out its functions and purposes, all in accordance with applicable State and federal law.

The Department may establish such subdivisions of the Department as shall be desirable and assign to the various subdivisions the responsibilities and duties placed upon the Department by the Laws of the State of Illinois.

The Department shall adopt, as necessary, rules for the execution of its powers. The provisions of the Illinois Administrative Procedure Act are hereby expressly adopted and shall apply to all administrative rules and procedures of the Department under this Act, except that Section 5-35 of the Illinois Administrative Procedure Act relating to procedures for rulemaking does not apply to the adoption of any rule required by federal law in connection with which the Department is precluded by law from exercising any discretion.

(c) Procurements necessary for the Department of Early Childhood to implement this Act are subject to the Illinois Procurement Code, except as otherwise provided in paragraph (25) of subsection (b) of Section 1-10 of that Code. The Department of Early Childhood is subject to the Business Enterprise for Minorities, Women, and Persons with Disabilities Act.

(Source: P.A. 103-594, eff. 6-25-24)."

The motion prevailed.

And the amendment was adopted and ordered printed.

Senator Aquino offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO SENATE BILL 406

AMENDMENT NO. 2. Amend Senate Bill 406, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 1, on page 1, line 16, after the period, by inserting "The ECIDS shall be designed and maintained to allow for data integration and sharing with other State agencies and other entities that maintain State data within the State early childhood ecosystem as needed for cross-agency collaboration and to the extent permitted by State and federal requirements.".

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendments numbered 1 and 2 were ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Aquino, **Senate Bill No. 406** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 52; NAY 1.

The following voted in the affirmative:

Anderson	Fine	Lightford	Syverson
Aquino	Fowler	Loughran Cappel	Tracy
Balkema	Glowiak Hilton	Martwick	Turner, S.
Bryant	Guzmán	McClure	Ventura
Castro	Halpin	Morrison	Villa
Cervantes	Harris, N.	Murphy	Villanueva
Collins	Harriss, E.	Peters	Villivalam
Cunningham	Hastings	Porfirio	Walker
Curran	Hills	Preston	Wilcox
DeWitte	Holmes	Rezin	Mr. President
Edly-Allen	Johnson	Rose	
Ellman	Jones, E.	Simmons	
Faraci	Koehler	Sims	
Feigenholtz	Lewis	Stadelman	

The following voted in the negative:

Arellano, L.

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Porfirio, **Senate Bill No. 637** was recalled from the order of third reading to the order of second reading.

Floor Amendment No. 1 was postponed in the Committee on Local Government.

Senator Porfirio offered the following amendment and moved its adoption:

[May 8, 2025]

AMENDMENT NO. 2 TO SENATE BILL 637

AMENDMENT NO. 2 . Amend Senate Bill 637 by replacing everything after the enacting clause with the following:

"Section 5. The Cook County Forest Preserve District Act is amended by changing Section 40 as follows:

(70 ILCS 810/40) (from Ch. 96 1/2, par. 6443)

Sec. 40. The corporate authorities of forest preserve districts, having the control or supervision of any forest preserves, may erect and maintain within such forest preserves, under the control or supervision of such corporate authorities, edifices to be used for the collection and display of animals as customary in zoological parks, and may collect and display such animals, or permit the directors or trustees of any zoological society devoted to the purposes aforesaid to erect and maintain a zoological park and to collect and display zoological collections within any forest preserve now or hereafter under the control or supervision of such forest preserve district, out of funds belonging to such zoological society, or to contract with the directors or trustees of any zoological society on such terms and conditions as may to such corporate authorities seem best, relative to the erection, operation and maintenance of a zoological park and the collection and display of such animals within such forest preserve, out of the tax provided in Section 41.

Such forest preserve district may charge, or permit such zoological society to charge an admission fee. The proceeds of such admission fee shall be devoted exclusively to the operation and maintenance of such zoological park and the collections therein. All such zoological parks shall be open to the public without charge for a period equivalent to 52 days each year. Beginning on the effective date of this amendatory Act of the 101st General Assembly through June 30, 2022, any such zoological parks shall be open to the public without charge for a period equivalent to 52 days. All such zoological parks shall be open without charge to organized groups of children in attendance at schools in the State. The managing authority of the zoological park may limit the number of any such groups in any given day and may establish other rules and regulations that reasonably ensure public safety, accessibility, and convenience, including but not limited to standards of conduct and supervision. Charges may be made at any time for special services and for admission to special facilities within any zoological park for the education, entertainment or convenience of visitors.

Subject to approval by the forest preserve district board, the managing authority of the zoological park may sublease or license no more than 15 acres of land within its boundaries for recreational use by a governmental entity or a not-for-profit organization to gain revenue in support of the zoological park's mission. A sublease or license under this Section shall expire after 40 years or upon the expiration of the contract between the forest preserve district and the zoological society, including renewal terms, whichever occurs first. The authority to sublease or license under this Section expires December 31, 2030.
(Source: P.A. 101-640, eff. 6-12-20.)

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

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendment No. 2 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Porfirio, **Senate Bill No. 637** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 55; NAYS None.

The following voted in the affirmative:

Anderson

Faraci

Koehler

Simmons

[May 8, 2025]

Aquino	Feigenholtz	Lewis	Sims
Arellano, L.	Fine	Lightford	Stadelman
Balkema	Fowler	Loughran Cappel	Syverson
Belt	Glowiak Hilton	Martwick	Tracy
Castro	Guzmán	McClure	Turner, S.
Cervantes	Halpin	Morrison	Ventura
Chesney	Harris, N.	Murphy	Villa
Collins	Harriss, E.	Peters	Villanueva
Cunningham	Hastings	Plummer	Villivalam
Curran	Hills	Porfirio	Walker
DeWitte	Holmes	Preston	Wilcox
Edly-Allen	Johnson	Rezin	Mr. President
Ellman	Jones, E.	Rose	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Aquino, **Senate Bill No. 798** was recalled from the order of third reading to the order of second reading.

Floor Amendment No. 1 was held in the Committee on Health and Human Services.

Senator Aquino offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO SENATE BILL 798

AMENDMENT NO. 2. Amend Senate Bill 798 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Health Facilities Planning Act is amended by changing Section 3 as follows:

(20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

(Section scheduled to be repealed on December 31, 2029)

Sec. 3. Definitions. As used in this Act:

"Health care facilities" means and includes the following facilities, organizations, and related persons:

(1) An ambulatory surgical treatment center required to be licensed pursuant to the Ambulatory Surgical Treatment Center Act.

(2) An institution, place, building, or agency required to be licensed pursuant to the Hospital Licensing Act.

(3) Skilled and intermediate long term care facilities licensed under the Nursing Home Care Act.

(A) If a demonstration project under the Nursing Home Care Act applies for a certificate of need to convert to a nursing facility, it shall meet the licensure and certificate of need requirements in effect as of the date of application.

(B) Except as provided in item (A) of this subsection, this Act does not apply to facilities granted waivers under Section 3-102.2 of the Nursing Home Care Act.

(3.5) Skilled and intermediate care facilities licensed under the ID/DD Community Care Act or the MC/DD Act. No permit or exemption is required for a facility licensed under the ID/DD Community Care Act or the MC/DD Act prior to the reduction of the number of beds at a facility. If there is a total reduction of beds at a facility licensed under the ID/DD Community Care Act or the MC/DD Act, this is a discontinuation or closure of the facility. If a facility licensed under the ID/DD Community Care Act or the MC/DD Act reduces the number of beds or discontinues the facility, that facility must notify the Board as provided in Section 14.1 of this Act.

(3.7) Facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013.

(4) Hospitals, nursing homes, ambulatory surgical treatment centers, or kidney disease treatment centers maintained by the State or any department or agency thereof.

(5) Kidney disease treatment centers, including a free-standing hemodialysis unit required to meet the requirements of 42 CFR 494 in order to be certified for participation in Medicare and Medicaid under Titles XVIII and XIX of the federal Social Security Act.

(A) This Act does not apply to a dialysis facility that provides only dialysis training, support, and related services to individuals with end stage renal disease who have elected to receive home dialysis.

(B) This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home.

(C) The Board, however, may require dialysis facilities and licensed nursing homes under items (A) and (B) of this subsection to report statistical information on a quarterly basis to the Board to be used by the Board to conduct analyses on the need for proposed kidney disease treatment centers.

(6) An institution, place, building, or room used for the performance of outpatient surgical procedures that is leased, owned, or operated by or on behalf of an out-of-state facility.

(7) An institution, place, building, or room used for provision of a health care category of service, including, but not limited to, cardiac catheterization and open heart surgery.

(8) An institution, place, building, or room housing major medical equipment used in the direct clinical diagnosis or treatment of patients, and whose project cost is in excess of the capital expenditure minimum.

"Health care facilities" does not include the following entities or facility transactions:

(1) Federally-owned facilities.

(2) Facilities used solely for healing by prayer or spiritual means.

(3) An existing facility located on any campus facility as defined in Section 5-5.8b of the Illinois Public Aid Code, provided that the campus facility encompasses 30 or more contiguous acres and that the new or renovated facility is intended for use by a licensed residential facility.

(4) Facilities licensed under the Supportive Residences Licensing Act or the Assisted Living and Shared Housing Act.

(5) Facilities designated as supportive living facilities that are in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code.

(6) Facilities established and operating under the Alternative Health Care Delivery Act as a children's community-based health care center alternative health care model demonstration program or as an Alzheimer's Disease Management Center alternative health care model demonstration program.

(7) The closure of an entity or a portion of an entity licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act, with the exception of facilities operated by a county or Illinois Veterans Homes, that elect to convert, in whole or in part, to an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act and with the exception of a facility licensed under the Specialized Mental Health Rehabilitation Act of 2013 in connection with a proposal to close a facility and re-establish the facility in another location.

(8) Any change of ownership of a health care facility that is licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act, with the exception of facilities operated by a county or Illinois Veterans Homes. Changes of ownership of facilities licensed under the Nursing Home Care Act must meet the requirements set forth in Sections 3-101 through 3-119 of the Nursing Home Care Act.

(9) (Blank).

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or

within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups, unless the entity constructs, modifies, or establishes a health care facility as specifically defined in this Section. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by item (a), (b), or (c).

"State Board" or "Board" means the Health Facilities and Services Review Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of a health care facility for (i) the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act or (ii) a conversion project undertaken in accordance with Section 30 of the Older Adult Services Act shall be excluded from any obligations under this Act.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site or the initiation of a category of service.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act. In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

"Capital expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Unless otherwise interdependent, or submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a single debt instrument shall not be grouped together as one project. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means \$11,500,000 for projects by hospital applicants, \$6,500,000 for applicants for projects related to skilled and intermediate care long-term care facilities licensed under the Nursing Home Care Act, and \$3,000,000 for projects by all other applicants, which shall be annually adjusted to reflect the increase in construction costs due to inflation, for major medical equipment and for all other capital expenditures.

"Financial commitment" means the commitment of at least 33% of total funds assigned to cover total project cost, which occurs by the actual expenditure of 33% or more of the total project cost or the commitment to expend 33% or more of the total project cost by signed contracts or other legal means.

"Non-clinical service area" means an area (i) for the benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; components in a patient care unit used as educational space, consultation and touchdown rooms, and on-call rooms; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. "Non-clinical service area" Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers, areas in a patient care unit, or areas that are required by Department licensing standards, including life safety code regulations, such as hallways and other interdependent components to a clinical area.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with the term "areawide".

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Physician" means a person licensed to practice in accordance with the Medical Practice Act of 1987, as amended.

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" or "Department" means the Illinois Department of Public Health.

"Alternative health care model" means a facility or program authorized under the Alternative Health Care Delivery Act.

"Out-of-state facility" means a person that is both (i) licensed as a hospital or as an ambulatory surgery center under the laws of another state or that qualifies as a hospital or an ambulatory surgery center under regulations adopted pursuant to the Social Security Act and (ii) not licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, or the Nursing Home Care Act. Affiliates of out-of-state facilities shall be considered out-of-state facilities. Affiliates of Illinois licensed health care facilities 100% owned by an Illinois licensed health care facility, its parent, or Illinois physicians licensed to practice medicine in all its branches shall not be considered out-of-state facilities. Nothing in this definition shall be construed to include an office or any part of an office of a physician licensed to practice medicine in all its branches in Illinois that is not required to be licensed under the Ambulatory Surgical Treatment Center Act.

"Change of ownership of a health care facility" means a change in the person who has ownership or control of a health care facility's physical plant and capital assets. A change in ownership is indicated by the following transactions: sale, transfer, acquisition, lease, change of sponsorship, or other means of transferring control.

"Related person" means any person that: (i) is at least 50% owned, directly or indirectly, by either the health care facility or a person owning, directly or indirectly, at least 50% of the health care facility; or (ii) owns, directly or indirectly, at least 50% of the health care facility.

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer.

"Freestanding emergency center" means a facility subject to licensure under Section 32.5 of the Emergency Medical Services (EMS) Systems Act.

"Category of service" means a grouping by generic class of various types or levels of support functions, equipment, care, or treatment provided to patients or residents, including, but not limited to, classes such as medical-surgical, pediatrics, or cardiac catheterization. A category of service may include

subcategories or levels of care that identify a particular degree or type of care within the category of service. Nothing in this definition shall be construed to include the practice of a physician or other licensed health care professional while functioning in an office providing for the care, diagnosis, or treatment of patients. A category of service that is subject to the Board's jurisdiction must be designated in rules adopted by the Board.

"State Board Staff Report" means the document that sets forth the review and findings of the State Board staff, as prescribed by the State Board, regarding applications subject to Board jurisdiction.

"Patient care unit" means a physically identifiable and organized unit in a clearly defined administrative and geographic area that meets applicable standards of service in which nursing care and therapeutic services are provided on a continuous basis and to which specific nursing and support staff are assigned. "Patient care unit" does not include education spaces, consultation and touchdown rooms, and on-call rooms that are not required by Department licensing standards.

"Provider" includes, but is not limited to, a hospital, long-term care facility, end-stage renal dialysis facility, ambulatory surgical treatment center, freestanding emergency center, or birth center.

(Source: P.A. 100-518, eff. 6-1-18; 100-581, eff. 3-12-18; 100-957, eff. 8-19-18; 101-81, eff. 7-12-19; 101-650, eff. 7-7-20.)".

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendment No. 2 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Aquino, **Senate Bill No. 798** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 56; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Lewis	Stadelman
Aquino	Feigenholtz	Lightford	Syverson
Arellano, L.	Fine	Loughran Cappel	Tracy
Balkema	Fowler	Martwick	Turner, S.
Belt	Glowiak Hilton	McClure	Ventura
Bryant	Guzmán	Morrison	Villa
Castro	Halpin	Murphy	Villanueva
Cervantes	Harris, N.	Peters	Villivalam
Chesney	Harriss, E.	Plummer	Walker
Collins	Hastings	Porfirio	Wilcox
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Johnson	Rose	
Edly-Allen	Jones, E.	Simmons	
Ellman	Koehler	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

[May 8, 2025]

SENATE BILL RECALLED

On motion of Senator Glowiak Hilton, **Senate Bill No. 1274** was recalled from the order of third reading to the order of second reading.

Senator Glowiak Hilton offered the following amendment and moved its adoption:

AMENDMENT NO. 3 TO SENATE BILL 1274

AMENDMENT NO. 3. Amend Senate Bill 1274, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Sexual Assault Survivors Emergency Treatment Act is amended by changing Section 5.2 as follows:

(410 ILCS 70/5.2)

Sec. 5.2. Sexual assault services voucher.

(a) A sexual assault services voucher shall be issued by a treatment hospital, treatment hospital with approved pediatric transfer, or approved pediatric health care facility at the time a sexual assault survivor receives medical forensic services.

(b) Each treatment hospital, treatment hospital with approved pediatric transfer, and approved pediatric health care facility must include in its sexual assault treatment plan submitted to the Department in accordance with Section 2 of this Act a protocol for issuing sexual assault services vouchers. The protocol shall, at a minimum, include the following:

(1) Identification of employee positions responsible for issuing sexual assault services vouchers.

(2) Identification of employee positions with access to the Medical Electronic Data Interchange or successor system.

(3) A statement to be signed by each employee of an approved pediatric health care facility with access to the Medical Electronic Data Interchange or successor system affirming that the Medical Electronic Data Interchange or successor system will only be used for the purpose of issuing sexual assault services vouchers.

(c) A sexual assault services voucher may be used to seek payment for any ambulance services, medical forensic services, laboratory services, pharmacy services, and follow-up healthcare provided as a result of the sexual assault.

(c-5) Beginning January 1, 2026, after services are provided to a survivor as a result of a sexual assault, a sexual assault services voucher may be used to seek payment for transportation to the hospital the survivor initially presented at, the survivor's residence, or a survivor services shelter by taxi or rideshare services, if available. A hospital may obtain written consent of the survivor to use taxi or rideshare services arranged by the hospital.

(d) Any treatment hospital, treatment hospital with approved pediatric transfer, approved pediatric health care facility, health care professional, ambulance provider, laboratory, or pharmacy may submit a bill for services provided to a sexual assault survivor as a result of a sexual assault to the Department of Healthcare and Family Services Sexual Assault Emergency Treatment Program. The bill shall include:

(1) the name and date of birth of the sexual assault survivor;

(2) the service provided;

(3) the charge of service;

(4) the date the service was provided; and

(5) the recipient identification number, if known.

A health care professional, ambulance provider, laboratory, or pharmacy is not required to submit a copy of the sexual assault services voucher.

The Department of Healthcare and Family Services Sexual Assault Emergency Treatment Program shall electronically verify, using the Medical Electronic Data Interchange or a successor system, that a sexual assault services voucher was issued to a sexual assault survivor prior to issuing payment for the services.

If a sexual assault services voucher was not issued to a sexual assault survivor by the treatment hospital, treatment hospital with approved pediatric transfer, or approved pediatric health care facility, then a health care professional, ambulance provider, laboratory, or pharmacy may submit a request to the

Department of Healthcare and Family Services Sexual Assault Emergency Treatment Program to issue a sexual assault services voucher.

(e) This Section is effective on and after January 1, 2024.

(Source: P.A. 101-634, eff. 6-5-20; 102-22, eff. 6-25-21; 102-674, eff. 11-30-21.)"

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendment No. 3 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Glowiak Hilton, **Senate Bill No. 1274** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 55; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Koehler	Simmons
Aquino	Feigenholtz	Lewis	Sims
Arellano, L.	Fine	Lightford	Stadelman
Balkema	Fowler	Loughran Cappel	Syverson
Belt	Glowiak Hilton	Martwick	Tracy
Bryant	Guzmán	McClure	Turner, S.
Castro	Halpin	Morrison	Ventura
Cervantes	Harris, N.	Murphy	Villa
Chesney	Harriss, E.	Peters	Villanueva
Collins	Hastings	Plummer	Villivalam
Cunningham	Hills	Porfirio	Walker
Curran	Holmes	Preston	Wilcox
DeWitte	Johnson	Rezin	Mr. President
Ellman	Jones, E.	Rose	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Murphy, **Senate Bill No. 851** was recalled from the order of third reading to the order of second reading.

Floor Amendment No. 1 was held in the Committee on Assignments.

Senator Murphy offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO SENATE BILL 851

AMENDMENT NO. 2 . Amend Senate Bill 851 by replacing everything after the enacting clause with the following:

"Section 5. The School Code is amended by changing Section 29-6.3 as follows:

(105 ILCS 5/29-6.3)

Sec. 29-6.3. Transportation to and from specified interscholastic or school-sponsored activities.

[May 8, 2025]

(a) Any school district transporting students in grade 12 or below for an interscholastic, interscholastic athletic, or school-sponsored, noncurriculum-related activity that (i) does not require student participation as part of the educational services of the district and (ii) is not associated with the students' regular class-for-credit schedule or required 5 clock hours of instruction under Section 10-19.05 shall transport the students only in a school bus, a vehicle manufactured to transport not more than 10 persons, including the driver, or a multifunction ~~school activity school activity~~ bus manufactured to transport not more than 15 persons, including the driver.

(a-5) A student in any of grades 9 through 12 may be transported in a ~~multifunction multi-function~~ school activity bus (MFSAB) as defined in Section 1-148.3a-5 of the Illinois Vehicle Code for any curriculum-related or career-related activity except for transportation on regular bus routes from home to school or from school to home, subject to the following conditions:

(i) A MFSAB may not be used to transport students under this Section unless the driver holds a valid school bus driver permit.

(ii) The use of a MFSAB under this Section is subject to the requirements of Sections 6-106.11, 6-106.12, 12-707.01, 13-101, and 13-109 of the Illinois Vehicle Code.

(b) Any school district furnishing transportation for students under the authority of this Section shall insure against any loss or liability of the district resulting from the maintenance, operation, or use of the vehicle.

(c) Vehicles used to transport students under this Section may claim a depreciation allowance of 20% over 5 years as provided in Section 29-5 of this Code.

(Source: P.A. 101-12, eff. 7-1-19.)

Section 10. The Illinois Vehicle Code is amended by changing Sections 1-148.3a-5 and 11-1414.1 as follows:

(625 ILCS 5/1-148.3a-5)

Sec. 1-148.3a-5. Multifunction school activity bus. A multifunction ~~school activity school activity~~ bus (MFSAB) means a school bus manufactured for the purpose of transporting 11 or more persons, including the driver, whose purposes do not include transporting students to and from home or school bus stops unless authorized by Article XIV of Chapter 11 of this Code or by Section 29-6.3 of the School Code. A MFSAB is prohibited from meeting the special requirements for school buses in Sections 12-801, 12-803, and 12-805 and subsection (a) of Section 12-802 of this Code.

(Source: P.A. 96-410, eff. 7-1-10; 97-378, eff. 8-15-11.)

(625 ILCS 5/11-1414.1) (from Ch. 95 1/2, par. 11-1414.1)

Sec. 11-1414.1. School transportation of students.

(a) Every student enrolled in grade 12 or below in any entity listed in subsection (a) of Section 1-182 of this Code must be transported in a school bus or a vehicle described in subdivision (1) or (2) of subsection (b) of Section 1-182 of this Code for any curriculum-related or career-related ~~school~~ activity, except a student in any of grades 9 through 12 or a student in any of grades K through 12 with an individualized education program ~~Individualized Education Plan~~ (IEP) with a staff to student ratio of 1 to 5, and attending Acacia Academy, Alexander Leigh, Marklund, Helping Hands Center, Connections Organization, Soaring Eagle Academy, or New Horizon Academy may be transported in a ~~multifunction~~ multifunction school activity bus (MFSAB) as defined in Section 1-148.3a-5 of this Code for any curriculum-related or career-related activity except for transportation on regular bus routes from home to school or from school to home, subject to the following conditions:

(i) A MFSAB may not be used to transport students under this Section unless the driver holds a valid school bus driver permit.

(ii) The use of a MFSAB under this Section is subject to the requirements of Sections 6-106.11, 6-106.12, 12-707.01, 13-101, and 13-109 of this Code.

"Curriculum-related or career-related ~~school~~ activity" as used in this subsection (a) includes transportation from home to school or from school to home, tripper or shuttle service between school attendance centers, transportation to a college, university, or student job site developed through a partnership with a school, a vocational or career center or other trade-skill development site or a regional safe school or other school-sponsored alternative learning program, or an experience that a school determines will contribute to the college or career readiness of a student, or a trip that is directly related to the regular curriculum of a student for which he or she earns credit.

(b) Every student enrolled in grade 12 or below in any entity listed in subsection (a) of Section 1-182 of this Code who is transported in a vehicle that is being operated by or for a public or private primary or secondary school, including any primary or secondary school operated by a religious institution, for an interscholastic, interscholastic-athletic, or school-sponsored, noncurriculum-related activity that (i) does not require student participation as part of the educational services of the entity and (ii) is not associated with the students' regular class-for-credit schedule shall transport students only in a school bus or vehicle described in subsection (b) of Section 1-182 of this Code. A student participating in an agrarian-related activity may also be transported in a second division pick-up truck registered under paragraph 7 of subsection (b) of Section 3-808.1. For purposes of this subsection, "pick-up truck" means a truck weighing 12,000 pounds or less with an enclosed cabin that can seat up to 6 passengers with seatbelts, including the driver, and an open cargo area. This subsection (b) does not apply to any second division vehicle used by an entity listed in subsection (a) of Section 1-182 of this Code for a parade, homecoming, or a similar noncurriculum-related school activity. (Source: P.A. 102-544, eff. 8-20-21.)"

The motion prevailed.

And the amendment was adopted and ordered printed.

Senator Murphy offered the following amendment and moved its adoption:

AMENDMENT NO. 3 TO SENATE BILL 851

AMENDMENT NO. 3. Amend Senate Bill 851 by replacing everything after the enacting clause with the following:

"Section 5. The School Code is amended by changing Section 29-6.3 as follows:

(105 ILCS 5/29-6.3)

Sec. 29-6.3. Transportation to and from specified interscholastic or school-sponsored activities.

(a) Any school district transporting students in grade 12 or below for an interscholastic, interscholastic athletic, or school-sponsored, noncurriculum-related activity that (i) does not require student participation as part of the educational services of the district and (ii) is not associated with the students' regular class-for-credit schedule or required 5 clock hours of instruction under Section 10-19.05 shall transport the students only in a school bus, a vehicle manufactured to transport not more than 10 persons, including the driver, or a multifunction school activity ~~school activity~~ bus manufactured to transport not more than 15 persons, including the driver.

(a-5) A student in any of grades 9 through 12 may be transported in a ~~multifunction~~ multi-function school activity bus (MFSAB) as defined in Section 1-148.3a-5 of the Illinois Vehicle Code for any curriculum-related career-related activity except for transportation on regular bus routes from home to school or from school to home, subject to the following conditions:

(i) A MFSAB may not be used to transport students under this Section unless the driver holds a valid school bus driver permit.

(ii) The use of a MFSAB under this Section is subject to the requirements of Sections 6-106.11, 6-106.12, 12-707.01, 13-101, and 13-109 of the Illinois Vehicle Code.

(b) Any school district furnishing transportation for students under the authority of this Section shall insure against any loss or liability of the district resulting from the maintenance, operation, or use of the vehicle.

(c) Vehicles used to transport students under this Section may claim a depreciation allowance of 20% over 5 years as provided in Section 29-5 of this Code.

(Source: P.A. 101-12, eff. 7-1-19.)

Section 10. The Illinois Vehicle Code is amended by changing Sections 1-148.3a-5 and 11-1414.1 as follows:

(625 ILCS 5/1-148.3a-5)

Sec. 1-148.3a-5. Multifunction school activity bus. A multifunction ~~school activity~~ ~~school activity~~ bus (MFSAB) means a school bus manufactured for the purpose of transporting 11 or more persons, including the driver, whose purposes do not include transporting students to and from home or school bus stops. A MFSAB is prohibited from meeting the special requirements for school buses in Sections 12-801, 12-803, and 12-805 and subsection (a) of Section 12-802 of this Code.

[May 8, 2025]

(Source: P.A. 96-410, eff. 7-1-10; 97-378, eff. 8-15-11.)

(625 ILCS 5/11-1414.1) (from Ch. 95 1/2, par. 11-1414.1)

Sec. 11-1414.1. School transportation of students.

(a) Every student enrolled in grade 12 or below in any entity listed in subsection (a) of Section 1-182 of this Code must be transported in a school bus or a vehicle described in subdivision (1) or (2) of subsection (b) of Section 1-182 of this Code for any curriculum-related or career-related ~~school~~ activity, except a student in any of grades 9 through 12 or a student in any of grades K through 12 with an individualized education program ~~Individualized Education Plan~~ (IEP) with a staff to student ratio of 1 to 5, and attending Acacia Academy, Alexander Leigh, Marklund, Helping Hands Center, Connections Organization, Soaring Eagle Academy, or New Horizon Academy may be transported in a ~~multifunction~~ ~~multi-function~~ school activity bus (MFSAB) as defined in Section 1-148.3a-5 of this Code for any curriculum-related or career-related activity except for transportation on regular bus routes from home to school or from school to home, subject to the following conditions:

(i) A MFSAB may not be used to transport students under this Section unless the driver holds a valid school bus driver permit.

(ii) The use of a MFSAB under this Section is subject to the requirements of Sections 6-106.11, 6-106.12, 12-707.01, 13-101, and 13-109 of this Code.

"Curriculum-related or career-related ~~school~~ activity" as used in this subsection (a) includes transportation from home to school or from school to home, tripper or shuttle service between school attendance centers, transportation to a college, university, or student job site developed through a partnership with a school, a vocational or career center or other trade-skill development site or a regional safe school or other school-sponsored alternative learning program, or an experience that a school determines will contribute to the college or career readiness of a student, or a trip that is directly related to the regular curriculum of a student for which he or she earns credit.

(b) Every student enrolled in grade 12 or below in any entity listed in subsection (a) of Section 1-182 of this Code who is transported in a vehicle that is being operated by or for a public or private primary or secondary school, including any primary or secondary school operated by a religious institution, for an interscholastic, interscholastic-athletic, or school-sponsored, noncurriculum-related activity that (i) does not require student participation as part of the educational services of the entity and (ii) is not associated with the students' regular class-for-credit schedule shall transport students only in a school bus or vehicle described in subsection (b) of Section 1-182 of this Code. A student participating in an agrarian-related activity may also be transported in a second division pick-up truck registered under paragraph 7 of subsection (b) of Section 3-808.1. For purposes of this subsection, "pick-up truck" means a truck weighing 12,000 pounds or less with an enclosed cabin that can seat up to 6 passengers with seatbelts, including the driver, and an open cargo area. This subsection (b) does not apply to any second division vehicle used by an entity listed in subsection (a) of Section 1-182 of this Code for a parade, homecoming, or a similar noncurriculum-related school activity.

(Source: P.A. 102-544, eff. 8-20-21.)."

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendments numbered 2 and 3 were ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Murphy, **Senate Bill No. 851** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 56; NAYS None.

The following voted in the affirmative:

Anderson

Faraci

Lewis

Stadelman

[May 8, 2025]

Aquino	Feigenholtz	Lightford	Syverson
Arellano, L.	Fine	Loughran Cappel	Tracy
Balkema	Fowler	Martwick	Turner, S.
Belt	Glowiak Hilton	McClure	Ventura
Bryant	Guzmán	Morrison	Villa
Castro	Halpin	Murphy	Villanueva
Cervantes	Harris, N.	Peters	Villivalam
Chesney	Harriss, E.	Plummer	Walker
Collins	Hastings	Porfirio	Wilcox
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Johnson	Rose	
Edly-Allen	Jones, E.	Simmons	
Ellman	Koehler	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Aquino, **Senate Bill No. 1486** was recalled from the order of third reading to the order of second reading.

Senator Aquino offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO SENATE BILL 1486

AMENDMENT NO. 2. Amend Senate Bill 1486, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Junk Fee Ban Act.

Section 5. Definitions. As used in this Act:

"Ancillary good or service" means any additional merchandise offered to a consumer as part of the same transaction.

"Advertisement" means a notice in any printed material, television, Internet, email, text message, mobile or computer application, or any other similar physical, electronic, or digital communication regarding the sale of a good or service.

"Bar" or "tavern" means an establishment that is devoted to the serving of alcoholic beverages for consumption by guests on the premises and that derives no more than 50% of its gross revenue from the sale of food consumed on the premises, including, but not limited to, bars, taverns, nightclubs, cocktail lounges, adult entertainment facilities, and cabarets.

"Consumer goods or services" means goods and services that are used or bought for use primarily for personal, family, or household purposes.

"Display price" means the displayed price of a good or service provided to the consumer within the retail mercantile establishment's physical location or by Internet, email, text message, mobile or computer application, or any other similar physical, electronic, or digital communication.

"Food service establishment" means a bar, tavern, or restaurant. "Food service establishment" includes bar, tavern, restaurant, commercial kitchen, or banquet, event, catering, or room service, operated by a hotel, that stores, prepares, provides, or packages food or beverage for human consumption, regardless of whether the food or beverage is consumed on or off the premises.

"Insurance company" has the meaning given to the term "company" in subsection (e) of Section 5 of the Illinois Insurance Code.

"Mandatory fee or charge" means a fee or charge that: (i) must be paid in order to purchase the goods or services being advertised or offered; or (ii) is not reasonably avoidable by the consumer. "Mandatory fee

[May 8, 2025]

or charge" does not include taxes or fees imposed by a governmental or quasi-governmental entity on the sale, use, purchase, receipt, or delivery of the goods or services.

"Person" means an individual, natural person, public or private corporation, government, partnership, unincorporated association, or other entity. "Person" does not include a food service establishment or a retail mercantile establishment.

"Place of short-term lodging" means a hotel, motel, inn, short-term rental, or other place of lodging that advertises at a price that is a nightly, hourly, or weekly rate.

"Restaurant" means any business that is primarily engaged in the sale of ready-to-eat food for immediate consumption. For the purpose of this definition, "primarily engaged" means having sales of ready-to-eat food for immediate consumption comprising at least 51% of the total sales, excluding the sale of liquor.

"Retail mercantile establishment" means a business that provides consumer goods and services to consumers at retail and generates occupation or use tax revenue. "Retail mercantile establishment" does not include a food service establishment or a place of short-term lodging.

"Shipping charges" means the fees or charges that reasonably reflect the amount to be incurred to send goods to a consumer through the mail, including private mail services.

"Third-party delivery platform or company" means a corporation, partnership, sole proprietorship, or other entity that: (i) operates in this State; and (ii) uses a website, software application, or digital network to connect a consumer with a courier to facilitate the delivery of goods or services.

"Total price" means the maximum total of all amounts, including fees or charges, that a consumer must pay for a good or service, including any mandatory ancillary good or service. "Total price" does not include shipping charges or taxes, gratuities, discounts regulated under the Sale Price Ad Act, or fees collected and passed on to a quasi-governmental entity, including any assessment fees associated with a government created special district.

Section 10. Disclosure of mandatory fees or charges required.

(a) It is an unlawful practice for any person to advertise, display, or offer a price for a good or service that does not include all mandatory fees or charges other than:

(1) taxes or fees imposed by a government entity on the transaction;

(2) shipping charges that will be reasonably and actually incurred to ship the physical good or product to the consumer; or

(3) fees collected and passed on to a quasi-governmental entity, including any assessment fees associated with a government created special district.

(b) A third-party delivery platform or company is compliant with this Section if the platform or company :

(1) clearly and conspicuously discloses at the point when a consumer views and selects either a vendor or goods or services for purchase, that an additional flat fee, variable fee, or percentage fee is charged and the amount of fee or percentage charged or, in the case of a variable fee that is dependent on consumer selections or distance and time, clearly and conspicuously disclose the factors determining the fee, any mandatory fees or charges associated with the transaction, and that the total price of the services may vary; and

(2) after a consumer selects the goods or services for purchase but prior to checkout or completion of the transaction, displays a subtotal page that itemizes the price of the goods or services for purchase and the additional flat fee, variable fee, or percentage fee that is included in the total price.

(c) A person offering services for which the total price of the service cannot reasonably be known at the time of the offer due to factors that determine the total price that are beyond the control of the person offering the service, including factors that are determined by consumer selections or preferences or that relate to distance or time, is compliant with this Section if the person discloses in a clear and conspicuous manner:

(1) the factors that determine the total price;

(2) any mandatory fees or charges associated with the transaction; and

(3) that the total price of the services may vary.

Section 15. Entities and transactions regulated by federal and State laws.

(a) A person or entity that is required to provide disclosures in compliance with any of the following federal or State laws, and any rules or regulations adopted under those laws, is exempt from the requirements of Section 10 for purposes of that transaction:

- (1) the federal Truth in Savings Act, as amended (12 U.S.C. Sec. 4301 et seq.);
- (2) the federal Electronic Fund Transfer Act, as amended (15 U.S.C. Sec. 1693 et seq.);
- (3) Section 19 of the Federal Reserve Act, as amended (12 U.S.C. Sec. 461 et seq.);
- (4) the federal Truth in Lending Act, as amended (15 U.S.C. Sec. 1601 et seq.);
- (5) the federal Real Estate Settlement Procedures Act, as amended (12 U.S.C. Sec. 2601 et seq.);
- (6) the federal Home Ownership and Equity Protection Act (15 U.S.C. Sec. 1639);
- (7) the Consumer Installment Loan Act;
- (8) the Consumer Legal Funding Act;
- (9) the Interest Act;
- (10) the Motor Vehicle Retail Installment Sales Act;
- (11) the Retail Installment Sales Act;
- (12) the Payday Loan Reform Act;
- (13) the High Risk Home Loan Act;
- (14) the Pawnbroker Regulation Act of 2023;
- (15) the Residential Mortgage Licensing Act of 1987;
- (16) the Residential Real Property Disclosure Act; and
- (17) the Student Loan Servicing Rights Act.

(b) Notwithstanding subsection (a), nothing in this Act shall apply to banks, savings banks, or credit unions organized or chartered under the laws of this State, another state, or the United States, or any affiliates or subsidiaries thereof.

Section 20. Retail mercantile establishments; disclosure of total price. A retail mercantile establishment is not required to provide the total price in the display price of a consumer good or service. A retail mercantile establishment shall provide notice of a consumer fee or charge established and levied by the retail mercantile establishment prior to the purchase of the good or service within any available commercial channels in this subsection. A retail mercantile establishment may use any reasonable method available to provide notice of the total price, including, but not limited to, the following commercial channels:

- (1) on a screen, monitor, or other display at the point of sale;
- (2) a website, Internet, email, text message, mobile or computer application, or any other electronic or digital communication;
- (3) in-store consumer promotions, advertisement, or any other similar display;
- (4) a membership, loyalty, or reward program or any other similar program; or
- (5) any other reasonable means available to the retail mercantile establishment.

Section 25. Food service establishments; disclosure of total price. A food service establishment is not required to provide the total price within the display price of food or beverages. A food service establishment shall provide notice of a consumer fee or charge established and levied by the food service establishment prior to the purchase of the food or beverage within any available commercial channels referenced in this subsection. A food service establishment may use any reasonable method available to provide notice of the total price, including, but not limited to, the following commercial channels:

- (1) at the establishment's premises on a menu, on a tabletop or countertop display, through posted signage, or by a contract for banquet, event or catering services that fully discloses the terms of service;
- (2) on the establishment's website where food and beverage prices are advertised;
- (3) on a screen, monitor, or other interactive display;
- (4) email, text message, mobile or computer application, or any other electronic or digital communication;
- (5) in-store consumer promotions, advertisement, or any other similar display;
- (6) membership, loyalty, or reward program or any other similar program; or
- (7) any other reasonable means available to the food service establishment.

Section 30. Limitations.

(a) Nothing in this Act shall be construed to limit, regulate, or prohibit a person, retail mercantile establishment, or food service establishment's ability to set prices for goods or services.

(b) It is not a violation of this Act for a person to advertise, display, or offer the current bid in an ongoing auction, provided that the bid discloses clearly and conspicuously all amounts that the buyer would be required to pay if the bid was accepted.

(c) The requirements of this Act do not apply to:

(1) a wholesale club that sells consumer goods or services through a membership model;

(2) a rental company that excludes from the advertised, displayed, or offered price of a rental vehicle charges that are disclosed to the consumer in compliance with Section 6-305 of the Illinois Vehicle Code;

(3) an air carrier that provides air transportation, as those terms are used in 49 U.S.C. 41713;

(4) a provider of broadband Internet access service on its own or as part of a bundle that complies with federal broadband consumer requirements codified in 47 CFR 8.2(a) and its affiliates and subsidiaries;

(5) a person that complies with federal pricing transparency requirements set forth in 47 CFR 8.2(a) and 47 CFR 76.310 and the person's affiliates and subsidiaries;

(6) a place of short-term lodging that complies with federal pricing transparency requirements and provisions set forth in 16 CFR 464a;

(7) an insurance company that is subject to regulation under the Illinois Insurance Code; and

(8) a telecommunications carrier as defined in Section 13-202 of the Public Utilities Act, a provider of wireless services as described in Section 13-804 of the Public Utilities Act, or an interconnected VoIP provider as defined in Section 13-235 of the Public Utilities Act.

(d) Nothing in this Act shall be construed to alter, amend, or supersede the motor vehicle advertising rules established under 14 Ill. Adm. Code 475, as authorized by the Consumer Fraud and Deceptive Business Practices Act.

(e) Any person that disseminates an advertisement and is independent of the advertiser is not liable for a violation of this Act based on the content of the advertisement.

Section 35. Interaction with other laws.

(a) Nothing in this Act alters any federal law or regulation.

(b) Nothing in this Act shall infringe or impede on any right or remedy available under State law or rule.

(c) This Act is enforceable unless preempted by federal law.

(d) Nothing in this Act prohibits a person from offering goods or services at a discounted price from the advertised, displayed, or offered price.

Section 40. Enforcement under the Consumer Fraud and Deceptive Business Practices Act. The Attorney General may enforce violations of this Act as an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act. All remedies, penalties, and authority granted to the Attorney General by that Act shall be available to the Attorney General for the enforcement of this Act.

Section 45. Home rule. The disclosure of the total price of a good or service is an exclusive power and function of the State. A home rule unit may not regulate the disclosure of total prices by retail mercantile establishments or food service establishments. This Section is a denial and limitation of home rule powers and functions under subsection (h) of Section 6 of Article VII of the Illinois Constitution.

Section 90. The Consumer Fraud and Deceptive Business Practices Act is amended by adding Section 2HHHH as follows:

(815 ILCS 505/2HHHH new)

Sec. 2HHHH. Violations of the Junk Fee Ban Act. A person who violates the Junk Fee Ban Act commits an unlawful practice within the meaning of this Act. The provisions of Section 10a do not apply to a violation of this Section."

The motion prevailed.

And the amendment was adopted and ordered printed.

Senator Aquino offered the following amendment and moved its adoption:

AMENDMENT NO. 3 TO SENATE BILL 1486

AMENDMENT NO. 3 . Amend Senate Bill 1486, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 2, on page 2, line 11, by replacing "establishment's" with "establishment or food service establishment's"; and

on page 3, line 22, by replacing "establishment or" with "establishment, third-party delivery platform or company, or".

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendments numbered 2 and 3 were ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Aquino, **Senate Bill No. 1486** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 53; NAY 1.

The following voted in the affirmative:

Anderson	Faraci	Koehler	Sims
Aquino	Feigenholtz	Lewis	Stadelman
Arellano, L.	Fine	Lightford	Tracy
Balkema	Fowler	Loughran Cappel	Turner, S.
Belt	Glowiak Hilton	Martwick	Ventura
Bryant	Guzmán	McClure	Villa
Castro	Halpin	Morrison	Villanueva
Cervantes	Harris, N.	Murphy	Villivalam
Collins	Harriss, E.	Peters	Walker
Cunningham	Hastings	Porfirio	Wilcox
Curran	Hills	Preston	Mr. President
DeWitte	Holmes	Rezin	
Edly-Allen	Johnson	Rose	
Ellman	Jones, E.	Simmons	

The following voted in the negative:

Chesney

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Harmon, as chief co-sponsor pursuant to Senate Rule 5-1(b)(i), **Senate Bill No. 1911** was recalled from the order of third reading to the order of second reading.

Senator Hunter offered the following amendment and Senator Harmon moved its adoption:

AMENDMENT NO. 3 TO SENATE BILL 1911

AMENDMENT NO. 3 . Amend Senate Bill 1911, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 2, on page 4, line 21, by replacing "(3) property" with "(3) in counties with a population of 3,000,000 or more inhabitants, property".

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendment No. 3 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Harmon, as chief co-sponsor pursuant to Senate Rule 5-1(b)(i), **Senate Bill No. 1911** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 54; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Koehler	Simmons
Aquino	Feigenholtz	Lewis	Sims
Arellano, L.	Fine	Lightford	Stadelman
Balkema	Fowler	Loughran Cappel	Syverson
Belt	Glowiak Hilton	Martwick	Tracy
Bryant	Guzmán	McClure	Turner, S.
Castro	Halpin	Morrison	Villa
Cervantes	Harris, N.	Murphy	Villanueva
Collins	Harriss, E.	Peters	Villivalam
Cunningham	Hastings	Plummer	Walker
Curran	Hills	Porfirio	Wilcox
DeWitte	Holmes	Preston	Mr. President
Edly-Allen	Johnson	Rezin	
Ellman	Jones, E.	Rose	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Villivalam, **Senate Bill No. 2253** was recalled from the order of third reading to the order of second reading.

Floor Amendment Nos. 1 and 2 were postponed in the Committee on Judiciary.

Senator Villivalam offered the following amendment and moved its adoption:

AMENDMENT NO. 3 TO SENATE BILL 2253

AMENDMENT NO. 3 . Amend Senate Bill 2253 by replacing everything after the enacting clause with the following:

"Section 5. The Department of Transportation Law of the Civil Administrative Code of Illinois is amended by changing Section 2705-405 and by adding Section 2705-407 as follows:

(20 ILCS 2705/2705-405) (was 20 ILCS 2705/49.25b)

Sec. 2705-405. Preparation of State Rail Plan. In preparation of the State Rail Plan under Section 2705-400, the Department shall consult with recognized railroad labor organizations, the Department of Commerce and Economic Opportunity, railroad management, all Class 1 and short line railroads, relevant businesses engaged in the railroad industry, affected units of local government, affected State agencies, and affected shipping interests.

(Source: P.A. 94-793, eff. 5-19-06.)

(20 ILCS 2705/2705-407 new)

Sec. 2705-407. Freight Rail Transportation Coordination Committee. The Department shall create a Freight Rail Coordination Committee to address highway projects that require coordination with Class 1 railroads. The Secretary shall appoint:

(1) One representative from each regional division within the Department.

(2) One representative from the Department with expertise in land acquisition.

(3) One representative from the Department with expertise in legal matters.

(4) One representative from the Department with expertise in design.

(5) Any other representatives from the Department as necessary.

(6) One representative from each Class 1 railroad in the State in consultation with the Class 1 railroad.

(7) One representative from a statewide association representing Class 1 railroads.

The Committee shall meet quarterly to discuss highway projects and work toward agreement on land rights issues, standardized construction, and maintenance agreements for all Class 1 railroads, standardizing procedures across the Department, and standardizing land acquisition processes within the Class 1 railroads.

This Section is repealed January 1, 2031.

Section 10. The Public Officer Prohibited Activities Act is amended by changing Section 3.1 as follows:

(50 ILCS 105/3.1) (from Ch. 102, par. 3.1)

Sec. 3.1. Before any contract relating to the ownership or use of real property is entered into by and between the State or any local governmental unit or any agency of either the identity of every owner and beneficiary having any interest, real or personal, in such property, and every member, shareholder, limited partner, or general partner entitled to receive more than 7 1/2% of the total distributable income of any limited liability company, corporation, or limited partnership having any interest, real or personal, in such property must be disclosed. The disclosure shall be in writing and shall be subscribed by a member, owner, authorized trustee, corporate official, general partner, or managing agent, or his or her authorized attorney or other authorized representative with knowledge of the information required by the disclosure, under oath. However, if the interest, stock, or shares in a limited liability company, corporation, or general partnership is publicly traded and there is no readily known individual having greater than a 7 1/2% interest, then a statement to that effect, subscribed to under oath by a member, officer of the corporation, general partner, or managing agent, or his or her authorized attorney, shall fulfill the disclosure statement requirement of this Section. The disclosure requirement of this Section may also be satisfied by providing a copy of the most recent proxy statement or other official corporate document filed in the previous calendar year with the federal Securities and Exchange Commission or similar federal regulatory body disclosing the overall ownership of the limited liability company, corporation or general partnership. As a condition of contracts entered into on or after the effective date of this amendatory Act of 1995, the beneficiaries of a lease shall furnish the trustee of a trust subject to disclosure under this Section with a binding non-revocable letter of direction authorizing the trustee to provide the State with an up-to-date disclosure whenever requested by the State. The letter of direction shall be binding on beneficiaries' heirs, successors, and assigns during the term of the contract. This Section shall be liberally construed to accomplish the purpose of requiring the identification of the actual parties benefiting from any transaction with a governmental unit or agency involving the procurement of the ownership or use of real property thereby.

For any entity that is wholly or partially owned by another entity, the names of the owners of the wholly or partially owning entity shall be disclosed under this Section, as well as the names of the owners of the wholly or partially owned entity. No such additional disclosure is required for contracts relating to the ownership or use of real property for highway purposes by the Department of Transportation.

(Source: P.A. 91-361, eff. 7-29-99.)

Section 15. The Eminent Domain Act is amended by changing Sections 10-5-10, 10-5-15, and 20-5-5 as follows:

(735 ILCS 30/10-5-10) (was 735 ILCS 5/7-102)

Sec. 10-5-10. Parties.

(a) When the right (i) to take private property for public use, without the owner's consent, (ii) to construct or maintain any public road, railroad, plankroad, turnpike road, canal, or other public work or improvement, or (iii) to damage property not actually taken has been or is conferred by general law or special charter upon any corporate or municipal authority, public body, officer or agent, person, commissioner, or corporation and when (i) the compensation to be paid for or in respect of the property sought to be appropriated or damaged for the purposes mentioned cannot be agreed upon by the parties interested, (ii) the owner of the property is incapable of consenting, (iii) the owner's name or residence is unknown, ~~or~~ (iv) the owner is a nonresident of the State, (v) the owner may agree on the compensation to be paid but is unable to convey clear title or provide all required documents to convey title or comply with any State or federal legal requirements to complete an acquisition by agreement, or (vi) the owner may agree on the compensation to be paid but the acquiring agency does not receive needed documents to enable processing of or the issuance of a warrant for the payment of compensation to the property owner, then the party authorized to take or damage the property so required, or to construct, operate, and maintain any public road, railroad, plankroad, turnpike road, canal, or other public work or improvement, may apply to the circuit court of the county where the property or any part of the property is situated, by filing with the clerk a complaint. The complaint shall set forth, by reference, (i) the complainant's authority in the premises, (ii) the purpose for which the property is sought to be taken or damaged, (iii) a description of the property, and (iv) the names of all persons interested in the property as owners or otherwise, as appearing of record, if known, or if not known stating that fact; and shall pray the court to cause the compensation to be paid to the owner to be assessed.

(b) If it appears that any person not in being, upon coming into being, is, or may become or may claim to be, entitled to any interest in the property sought to be appropriated or damaged, the court shall appoint some competent and disinterested person as guardian ad litem to appear for and represent that interest in the proceeding and to defend the proceeding on behalf of the person not in being. Any judgment entered in the proceeding shall be as effectual for all purposes as though the person was in being and was a party to the proceeding.

(c) If the proceeding seeks to affect the property of persons under guardianship, the guardians shall be made parties defendant.

(d) Any interested persons whose names are unknown may be made parties defendant by the same descriptions and in the same manner as provided in other civil cases.

(e) When the property to be taken or damaged is a common element of property subject to a declaration of condominium ownership, pursuant to the Condominium Property Act, or of a common interest community, the complaint shall name the unit owners' association in lieu of naming the individual unit owners and lienholders on individual units. Unit owners, mortgagees, and other lienholders may intervene as parties defendant. For the purposes of this Section, "common interest community" has the same meaning as set forth in subsection (c) of Section 9-102 of the Code of Civil Procedure. "Unit owners' association" or "association" shall refer to both the definition contained in Section 2 of the Condominium Property Act and subsection (c) of Section 9-102 of the Code of Civil Procedure.

(f) When the property is sought to be taken or damaged by the State for the purposes of establishing, operating, or maintaining any State house or State charitable or other institutions or improvements, the complaint shall be signed by the Governor, or the Governor's designee, or as otherwise provided by law.

(g) No property, except property described in Section 3 of the Sports Stadium Act, property to be acquired in furtherance of actions under Article 11, Divisions 124, 126, 128, 130, 135, 136, and 139, of the Illinois Municipal Code, property to be acquired in furtherance of actions under Section 3.1 of the Intergovernmental Cooperation Act, property to be acquired that is a water system or waterworks pursuant to the home rule powers of a unit of local government, property described as Site B in Section 2 of the Metropolitan Pier and Exposition Authority Act, and property that may be taken as provided in the Public-Private Agreements for the South Suburban Airport Act belonging to a railroad or other public utility subject to the jurisdiction of the Illinois Commerce Commission, may be taken or damaged, pursuant to the provisions of this Act, without the prior approval of the Illinois Commerce Commission. For property to be acquired by the Department of Transportation under Article 4, Division 5 or Article 8 of the Illinois Highway Code, the Commission shall issue its final order within 6 months after the date that the petition is

filed unless the Commission extends the period for issuing a final order. The Commission may extend the 6-month period for an additional 3 months on its own motion, or on a petition filed with good cause by any party. The Commission may grant such extension upon finding of good cause. If the Commission extends the period for issuing a final order, then the schedule for the proceeding shall not be further extended beyond this 3-month period, and the Commission shall issue its final order within the extension period. The Commission shall also have the power to establish an expedited schedule for making its determination on a petition filed by the Department of Transportation in less than 6 months if it finds that the public interest requires the setting of such an expedited schedule.

(h) Notwithstanding subsection (g), property belonging to a public utility that provides water or sewer service and that is subject to the jurisdiction of the Illinois Commerce Commission may not be taken or damaged by eminent domain without prior approval of the Illinois Commerce Commission, except for property to be acquired by a municipality with 140,000 or more inhabitants or a regional water commission formed under Article 11, Division 135.5 of the Illinois Municipal Code or a municipality that is a member of such a regional water commission, only in furtherance of purposes authorized under Article 11, Division 135.5 of the Illinois Municipal Code, and limited solely to interests in real property and not improvements to or assets on the real property belonging to a public utility that provides water or sewer service and that is subject to the jurisdiction of the Illinois Commerce Commission. This subsection does not apply to any action commenced prior to the effective date of this amendatory Act of the 103rd General Assembly under this Section or Section 11-124-5 or 11-139-12 of the Illinois Municipal Code.

(Source: P.A. 103-13, eff. 6-9-23.)

(735 ILCS 30/10-5-15) (was 735 ILCS 5/7-102.1)

Sec. 10-5-15. State agency proceedings; information.

(a) This Section applies only to the State and its agencies, and only to matters arising after December 31, 1991.

(b) Before any State agency initiates any proceeding under this Act, the agency must designate and provide for an appropriate person to respond to requests arising from the notifications required under this Section. The designated person may be an employee of the agency itself or an employee of any other appropriate State agency. The designated person shall respond to property owners' questions about the authority and procedures of the State agency in acquiring property by condemnation and about the property owner's general rights under those procedures. However, the designated person shall not provide property owners with specific legal advice or specific legal referrals.

(c) At the time of first contact with a property owner, whether in person or by letter, the State agency shall advise the property owner, in writing, of the following:

(1) A description of the property that the agency seeks to acquire.

(2) The name, address, and telephone number of the State official designated under subsection

(b) to answer the property owner's questions.

(3) The identity of the State agency attempting to acquire the property.

(4) The general purpose of the proposed acquisition.

(5) The type of facility to be constructed on the property, if any.

(d) At least 60 days before filing a petition with any court to initiate a proceeding under this Act, a State agency shall send a letter in any one of the following ways:

(I) by the United States Postal Service, certified mail, return receipt requested;

(II) by a designated private delivery service as defined by the Internal Revenue Service that provides the same function as certified mail with return receipts; or

(III) the letter is personally served;

A letter under this Section shall be sent to the owner of the property to be taken or, in the case of a corporation or other business organization, to the registered agent of the owner setting forth the following information, giving the property owner the following information:

(1) The amount of compensation for the taking of the property proposed by the agency and the basis for computing it.

(2) A statement that the agency continues to seek a negotiated agreement with the property owner.

(3) A statement that, in the absence of a negotiated agreement, it is the intention of the agency to initiate a court proceeding under this Act.

The State agency shall maintain a record of the letters sent in compliance with this Section for at least one year.

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(e) Any duty imposed on a State agency by this Section may be assumed by the Office of the Attorney General, the Capital Development Board, or any other agency of State government that is assisting or acting on behalf of the State agency in the matter.

(Source: P.A. 94-1055, eff. 1-1-07.)

(735 ILCS 30/20-5-5) (was 735 ILCS 5/7-103)

Sec. 20-5-5. Quick-take.

(a) This Section applies only to proceedings under this Article that are authorized in this Article and in Article 25 of this Act.

(b) In a proceeding subject to this Section, the plaintiff, at any time after the complaint has been filed and before judgment is entered in the proceeding, may file a written motion requesting that, immediately or at some specified later date, the plaintiff either: (i) be vested with the fee simple title (or such lesser estate, interest, or easement, as may be required) to the real property, or a specified portion of that property, which is the subject of the proceeding, and be authorized to take possession of and use the property; or (ii) only be authorized to take possession of and to use the property, if possession and use, without the vesting of title, are sufficient to permit the plaintiff to proceed with the project until the final ascertainment of compensation. No land or interests in land now or hereafter owned, leased, controlled, or operated and used by, or necessary for the actual operation of, any common carrier engaged in interstate commerce, or any other public utility subject to the jurisdiction of the Illinois Commerce Commission, shall be taken or appropriated under this Section by the State of Illinois, the Illinois Toll Highway Authority, the sanitary district, the St. Louis Metropolitan Area Airport Authority, or the Board of Trustees of the University of Illinois without first securing the approval of the Illinois Commerce Commission. For property to be acquired by the Department of Transportation under Article 4, Division 5 or Article 8 of the Illinois Highway Code, the Commission shall issue its final order within 6 months after the date that the petition is filed unless the Commission extends the period for issuing a final order. The Commission may extend the 6-month period for an additional 3 months on its own motion, or on a petition filed with good cause by any party. The Commission may grant such extension upon finding of good cause. If the Commission extends the period for issuing a final order, then the schedule for the proceeding shall not be further extended beyond this 3-month period, and the Commission shall issue its final order within the extension period. The Commission shall also have the power to establish an expedited schedule for making its determination on a petition filed by the Department of Transportation in less than 6 months if it finds that the public interest requires the setting of such an expedited schedule.

Except as otherwise provided in this Article, the motion for taking shall state: (1) an accurate description of the property to which the motion relates and the estate or interest sought to be acquired in that property; (2) the formally adopted schedule or plan of operation for the execution of the plaintiff's project; (3) the situation of the property to which the motion relates, with respect to the schedule or plan; (4) the necessity for taking the property in the manner requested in the motion; and (5) if the property (except property described in Section 3 of the Sports Stadium Act or property described as Site B in Section 2 of the Metropolitan Pier and Exposition Authority Act) to be taken is owned, leased, controlled, or operated and used by, or necessary for the actual operation of, any interstate common carrier or other public utility subject to the jurisdiction of the Illinois Commerce Commission, a statement to the effect that the approval of the proposed taking has been secured from the Commission, and attaching to the motion a certified copy of the order of the Illinois Commerce Commission granting approval. If the schedule or plan of operation is not set forth fully in the motion, a copy of the schedule or plan shall be attached to the motion.

The Department of Transportation shall report to the General Assembly no later than January 31 of each year the number of cases filed with the Illinois Commerce Commission under this Article during the previous year and the length of time taken, in months, to issue each final order during the previous calendar year.

(Source: P.A. 94-1055, eff. 1-1-07.)

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

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendment No. 3 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

[May 8, 2025]

READING BILLS OF THE SENATE A THIRD TIME

On motion of Senator Villivalam, **Senate Bill No. 2253** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 56; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Lewis	Stadelman
Aquino	Feigenholtz	Lightford	Syverson
Arellano, L.	Fine	Loughran Cappel	Tracy
Balkema	Fowler	Martwick	Turner, S.
Belt	Glowiak Hilton	McClure	Ventura
Bryant	Guzmán	Morrison	Villa
Castro	Halpin	Murphy	Villanueva
Cervantes	Harris, N.	Peters	Villivalam
Chesney	Harriss, E.	Plummer	Walker
Collins	Hastings	Porfirio	Wilcox
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Johnson	Rose	
Edly-Allen	Jones, E.	Simmons	
Ellman	Koehler	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

SENATE BILL RECALLED

On motion of Senator Murphy, **Senate Bill No. 2426** was recalled from the order of third reading to the order of second reading.

Senator Murphy offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO SENATE BILL 2426

AMENDMENT NO. 2 . Amend Senate Bill 2426, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Department of Natural Resources (Conservation) Law of the Civil Administrative Code of Illinois is amended by changing Section 805-540 as follows:

(20 ILCS 805/805-540) (was 20 ILCS 805/63b2.6)

Sec. 805-540. Enforcement of adjoining state's laws. The Director may grant authority to the officers of any adjoining state who are authorized and directed to enforce the laws of that state relating to the protection of flora and fauna to take any of the following actions and have the following powers within the State of Illinois:

(1) To follow, seize, and return to the adjoining state any flora or fauna or part thereof shipped or taken from the adjoining state in violation of the laws of that state and brought into this State.

(2) To dispose of any such flora or fauna or part thereof under the supervision of an Illinois Conservation Police Officer.

(3) To enforce as an agent of this State, with the same powers as an Illinois Conservation Police Officer, each of the following laws of this State:

(i) The Illinois Endangered Species Protection Act.

- (ii) The Fish and Aquatic Life Code.
- (iii) The Wildlife Code.
- (iv) The Wildlife Habitat Management Areas Act.
- (v) Section 48-3 of the Criminal Code of 2012 (hunter or fisherman interference).
- (vi) The Illinois Non-Game Wildlife Protection Act.
- (vii) The Ginseng Harvesting Act.
- (viii) The State Forest Act.
- (ix) The Timber Transportation Act ~~Forest Products Transportation Act~~.
- (x) The Timber Buyers Licensing Act.

Any officer of an adjoining state acting under a power or authority granted by the Director pursuant to this Section shall act without compensation or other benefits from this State and without this State having any liability for the acts or omissions of that officer.

(Source: P.A. 96-397, eff. 1-1-10; 97-1108, eff. 1-1-13; 97-1150, eff. 1-25-13.)

Section 10. The Forest Products Transportation Act is amended by changing Sections 1, 2, 3, 5, 6, 13, and 14 and by adding Sections 6.5 and 6.8 as follows:

(225 ILCS 740/1) (from Ch. 96 1/2, par. 6901)

Sec. 1. This Act shall be known and may be cited as the Timber Transportation Act ~~"Forest Products Transportation Act"~~.

(Source: P.A. 77-2801.)

(225 ILCS 740/2) (from Ch. 96 1/2, par. 6902)

Sec. 2. As used in this Act, unless the context otherwise requires: ~~the terms defined in the Sections following this Section and preceding Section 3 have the meanings ascribed to them in those Sections.~~

"Christmas tree" means a coniferous evergreen species of tree, such as spruce, pine, or fir, that is intended to be used solely for holiday decoration.

"Commercial tree care business" means a business working in this State that is hired by a property owner, governmental agency, or utility for the purpose of providing tree care services, including pruning and tree removal.

"Firewood" means any tree or part thereof which is harvested, is to be used solely for fuel, and is cut into lengths not exceeding 48 inches.

"Person" means any person, partnership, firm, association, limited liability company, business, trust, or corporation.

"Proof of ownership" means a printed document provided by the Department that serves as a written bill of sale, a bill of lading, a work order or signed sales contract associated with a commercial tree care business, an executed tree removal permit, or any other document or method of showing legal possession of timber that is approved by the Department in administrative rule, including digital copies.

"Timber" means trees and parts thereof which can be used for sawing or processing into lumber for building or structural purposes or for the manufacture of any article. "Timber" does not include firewood, Christmas trees, fruit or ornamental trees, or wood products not used or to be used for building, structural, manufacturing, or processing purposes.

"Tree" or "trees" means a woody perennial plant, typically having a single stem or trunk, growing to a height and bearing lateral branches at some distance from the ground.

(Source: P.A. 97-333, eff. 8-12-11.)

(225 ILCS 740/3) (from Ch. 96 1/2, par. 6910)

Sec. 3. Nothing in this Act affects the rights of the owners of trees ~~or forest products~~ nor imposes any duties or liabilities on them not otherwise imposed by law. This Act is, rather, intended to protect the rights of the owners of trees, ~~identify the transportation of stolen timber, and protect the~~ and forest products as well as the interests of the public interest in trees and forest products on public lands.

(Source: P.A. 77-2801.)

(225 ILCS 740/5) (from Ch. 96 1/2, par. 6912)

Sec. 5. No person who is subject to the Timber Buyers Licensing Act may haul or transport any ~~timber tree or forest product~~ timber tree or forest product on the highways of this State without proof of ownership as required by the Department by administrative rule ~~the written consent of the timber grower or subsequent seller.~~

(Source: P.A. 85-294.)

(225 ILCS 740/6) (from Ch. 96 1/2, par. 6913)

Sec. 6. Any person hauling or transporting ~~timber 2 or more trees and forest products, or either of them,~~ on any highway in this State shall be required to show proof of ownership as defined in ~~Section 2.06~~ of this Act, except that interstate transporters originating outside of this State and traveling to destinations within or outside of this State may show documents in accordance with federal Motor Carrier Safety Administration rules in lieu of such proof of ownership.

If ~~any that~~ any person who is subject to this Act is unable to show proof of ownership, the ~~timber and forest products~~ so hauled or transported, and the vehicle or conveyance used as the means of transportation may be held by the Department for disposition subject to court order. The information required for proof of ownership shall be set by the Department by administrative rule.

(Source: P.A. 92-805, eff. 8-21-02.)

(225 ILCS 740/6.5 new)

Sec. 6.5. Inspection. The Department or any law enforcement agency may inspect any vehicle or conveyance hauling or transporting timber on any road or highway in this State to determine if the transportation of the timber complies with this Act. If an officer of the Department or law enforcement agency discovers any violation of this Act, the officer may issue a summons to the person operating the vehicle that is hauling or transporting the timber that requires that the person appears before the circuit court for the county within which the offense was committed.

(225 ILCS 740/6.8 new)

Sec. 6.8. Violations.

(a) Every person hauling a tree or trees shall be subject to this Act, and upon the request of a designated law enforcement officer to stop hauling the tree or trees, must stop immediately and provide required proof of ownership.

(b) Proof of ownership shall be available for inspection at all times and shall be kept with the vehicle or other conveyance load.

(c) No person shall willfully fail or refuse to comply with any lawful order or direction of any officer authorized by law to enforce this Act.

(d) No person shall knowingly falsify any information required on any proof of ownership or provide false information to any person that results in false information being provided on any proof of ownership.

(225 ILCS 740/13) (from Ch. 96 1/2, par. 6920)

Sec. 13. It shall be unlawful for any person to resist or obstruct any officer, employee or agent of the Department in the discharge of his duties under the provisions of this Act.

Violation of this Act or any administrative rules adopted under this Act ~~Section~~ shall be a Class C ~~Class A~~ misdemeanor.

(Source: P.A. 85-294.)

(225 ILCS 740/14)

Sec. 14. Any ~~timber, forestry,~~ or wood cutting device or equipment, including vehicles and conveyances used or operated in violation of this Act or rules adopted under this Act or attempted to be used in violation of this Act or rules adopted under this Act shall be deemed a public nuisance and subject to seizure and confiscation by any authorized employee of the Department. Upon the seizure of such an item the Department shall take and hold the item until disposed of as provided in this Section.

Upon the seizure of any property pursuant to this Section, the authorized employee of the Department making the seizure shall forthwith cause a complaint to be filed before the circuit court and a summons to be issued requiring the person who illegally used or operated or attempted to use or operate the property and the owner and person in possession of the property to appear in court and show cause why the seized property should not be forfeited to the State. Upon the return of the summons duly served or other notice as provided in this Section, the court shall proceed to determine the question of the illegality of the use of the seized property and upon judgment being entered to the effect that the property was illegally used, an order may be entered providing for the forfeiture of the seized property to the Department, which shall thereupon become the property of the Department. However, the owner of the property may have a jury determine the illegality of its use and shall have the right of an appeal as in other cases. Such a confiscation or forfeiture shall not preclude or mitigate against prosecution and assessment of penalties otherwise provided in this Act.

Upon seizure of any property under circumstances supporting a reasonable belief that the property was abandoned, lost, stolen, or otherwise illegally possessed or used contrary to the provisions of this Act, except property seized during a search or arrest and ultimately returned, destroyed, or otherwise disposed of pursuant to a court order in accordance with this Act, the authorized employee of the Department shall make

reasonable inquiry and efforts to identify and notify the owner or other person entitled to possession thereof and shall return the property after that person provides reasonable and satisfactory proof of his or her ownership or right to possession and reimburses the Department for all reasonable expenses of such custody. If the identity or location of the owner or other person entitled to possession of the property has not been ascertained within 6 months after the Department obtains possession, the Department shall effectuate the sale of the property for cash to the highest bidder at a public auction. The owner or other person entitled to possession of the property may claim and recover possession of the property at any time before its sale at public auction upon providing reasonable and satisfactory proof of ownership or right of possession and after reimbursing the Department for all reasonable expenses of custody thereof.

Any property forfeited to the State by court order pursuant to this Section may be disposed of by public auction, except that any property that is the subject of such a court order shall not be disposed of pending appeal of the order. The proceeds of the sale at auction shall be deposited in the Illinois Forestry Development Fund.

The Department shall pay all costs of notices required by this Section.

(Source: P.A. 92-805, eff. 8-21-02.)

(225 ILCS 740/2.02 rep.)

(225 ILCS 740/2.03 rep.)

(225 ILCS 740/2.04 rep.)

(225 ILCS 740/2.05 rep.)

(225 ILCS 740/2.06 rep.)

(225 ILCS 740/2.07 rep.)

Section 15. The Forest Products Transportation Act is amended by repealing Sections 2.02, 2.03, 2.04, 2.05, 2.06, and 2.07.

Section 20. The Criminal and Traffic Assessment Act is amended by changing Section 1-5 as follows:
(705 ILCS 135/1-5)

Sec. 1-5. Definitions. In this Act:

"Assessment" means any costs imposed on a defendant under schedules 1 through 13 of this Act.

"Business offense" means any offense punishable by a fine in excess of \$1,000 and for which a sentence of imprisonment is not an authorized disposition.

"Case" means all charges and counts filed against a single defendant which are being prosecuted as a single proceeding before the court.

"Count" means each separate offense charged in the same indictment, information, or complaint when the indictment, information, or complaint alleges the commission of more than one offense.

"Conservation offense" means any violation of the following Acts, Codes, or ordinances, except any offense punishable upon conviction by imprisonment in the penitentiary:

(1) Fish and Aquatic Life Code;

(2) Wildlife Code;

(3) Boat Registration and Safety Act;

(4) Park District Code;

(5) Chicago Park District Act;

(6) State Parks Act;

(7) State Forest Act;

(8) Forest Fire Protection District Act;

(9) Snowmobile Registration and Safety Act;

(10) Endangered Species Protection Act;

(11) ~~Timber Transportation Act~~ ~~Forest Products Transportation Act~~;

(12) Timber Buyers Licensing Act;

(13) Downstate Forest Preserve District Act;

(14) Illinois Exotic Weeds Act;

(15) Ginseng Harvesting Act;

(16) Cave Protection Act;

(17) ordinances adopted under the Counties Code for the acquisition of property for parks or recreational areas;

(18) Recreational Trails of Illinois Act;

(19) Herptiles-Herps Act; or

(20) any rule, regulation, proclamation, or ordinance adopted under any Code or Act named in paragraphs (1) through (19) of this definition.

"Conviction" means a judgment of conviction or sentence entered upon a plea of guilty or upon a verdict or finding of guilty of an offense, rendered by a legally constituted jury or by a court of competent jurisdiction authorized to try the case without a jury.

"Drug offense" means any violation of the Cannabis Control Act, the Illinois Controlled Substances Act, the Methamphetamine Control and Community Protection Act, or any similar local ordinance which involves the possession or delivery of a drug.

"Drug-related emergency response" means the act of collecting evidence from or securing a site where controlled substances were manufactured, or where by-products from the manufacture of controlled substances are present, and cleaning up the site, whether these actions are performed by public entities or private contractors paid by public entities.

"Electronic citation" means the process of transmitting traffic, misdemeanor, ordinance, conservation, or other citations and law enforcement data via electronic means to a circuit court clerk.

"Emergency response" means any incident requiring a response by a police officer, an ambulance, a firefighter carried on the rolls of a regularly constituted fire department or fire protection district, a firefighter of a volunteer fire department, or a member of a recognized not-for-profit rescue or emergency medical service provider. "Emergency response" does not include a drug-related emergency response.

"Felony offense" means an offense for which a sentence to a term of imprisonment in a penitentiary for one year or more is provided.

"Fine" means a pecuniary punishment for a conviction or supervision disposition as ordered by a court of law.

"Highest classified offense" means the offense in the case which carries the most severe potential disposition under Article 4.5 of Chapter V of the Unified Code of Corrections.

"Major traffic offense" means a traffic offense, as defined by paragraph (f) of Supreme Court Rule 501, other than a petty offense or business offense.

"Minor traffic offense" means a traffic offense, as defined by paragraph (f) of Supreme Court Rule 501, that is a petty offense or business offense.

"Misdemeanor offense" means any offense for which a sentence to a term of imprisonment in other than a penitentiary for less than one year may be imposed.

"Offense" means a violation of any local ordinance or penal statute of this State.

"Petty offense" means any offense punishable by a fine of up to \$1,000 and for which a sentence of imprisonment is not an authorized disposition.

"Service provider costs" means costs incurred as a result of services provided by an entity including, but not limited to, traffic safety programs, laboratories, ambulance companies, and fire departments. "Service provider costs" includes conditional amounts under this Act that are reimbursements for services provided.

"Street value" means the amount determined by the court on the basis of testimony of law enforcement personnel and the defendant as to the amount of drug or materials seized and any testimony as may be required by the court as to the current street value of the cannabis, controlled substance, methamphetamine or salt of an optical isomer of methamphetamine, or methamphetamine manufacturing materials seized.

"Supervision" means a disposition of conditional and revocable release without probationary supervision, but under the conditions and reporting requirements as are imposed by the court, at the successful conclusion of which disposition the defendant is discharged and a judgment dismissing the charges is entered.

(Source: P.A. 103-620, eff. 1-1-25.)".

The motion prevailed.

And the amendment was adopted and ordered printed.

There being no further amendments, the foregoing Amendment No. 2 was ordered engrossed, and the bill, as amended, was ordered to a third reading.

[May 8, 2025]

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Murphy, **Senate Bill No. 2426** having been transcribed and typed and all amendments adopted thereto having been printed, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 56; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Lewis	Stadelman
Aquino	Feigenholtz	Lightford	Syverson
Arellano, L.	Fine	Loughran Cappel	Tracy
Balkema	Fowler	Martwick	Turner, S.
Belt	Glowiak Hilton	McClure	Ventura
Bryant	Guzmán	Morrison	Villa
Castro	Halpin	Murphy	Villanueva
Cervantes	Harris, N.	Peters	Villivalam
Chesney	Harriss, E.	Plummer	Walker
Collins	Hastings	Porfirio	Wilcox
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Johnson	Rose	
Edly-Allen	Jones, E.	Simmons	
Ellman	Koehler	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

CONSIDERATION OF RESOLUTIONS ON SECRETARY'S DESK

Senator Anderson moved that **Senate Resolution No. 25**, on the Secretary's Desk, be taken up for immediate consideration.

The motion prevailed.

Senator Anderson moved that Senate Resolution No. 25 be adopted.

The motion prevailed.

And the resolution was adopted.

Senator Fine moved that **Senate Resolution No. 100**, on the Secretary's Desk, be taken up for immediate consideration.

The motion prevailed.

Senator Fine moved that Senate Resolution No. 100 be adopted.

The motion prevailed.

And the resolution was adopted.

Senator Fine moved that **Senate Resolution No. 105**, on the Secretary's Desk, be taken up for immediate consideration.

The motion prevailed.

Senator Fine moved that Senate Resolution No. 105 be adopted.

The motion prevailed.

And the resolution was adopted.

Senator S. Turner moved that **Senate Resolution No. 241**, on the Secretary’s Desk, be taken up for immediate consideration.

The motion prevailed.

Senator S. Turner moved that Senate Resolution No. 241 be adopted.

The motion prevailed.

And the resolution was adopted.

Senator Villa moved that **Senate Resolution No. 248**, on the Secretary’s Desk, be taken up for immediate consideration.

The motion prevailed.

Senator Villa moved that Senate Resolution No. 248 be adopted.

The motion prevailed.

And the resolution was adopted.

Senator Fowler moved that **Senate Joint Resolution No. 33**, on the Secretary’s Desk, be taken up for immediate consideration.

The motion prevailed.

Senator Fowler moved that Senate Joint Resolution No. 33 be adopted.

And on that motion, a call of the roll was had resulting as follows:

YEAS 55; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Koehler	Simmons
Aquino	Feigenholtz	Lewis	Sims
Arellano, L.	Fine	Lightford	Stadelman
Balkema	Fowler	Loughran Cappel	Syverson
Belt	Glowiak Hilton	Martwick	Tracy
Bryant	Guzmán	McClure	Turner, S.
Castro	Halpin	Morrison	Ventura
Cervantes	Harris, N.	Murphy	Villa
Chesney	Harris, E.	Peters	Villanueva
Collins	Hastings	Plummer	Villivalam
Cunningham	Hills	Porfirio	Walker
Curran	Holmes	Preston	Wilcox
Edly-Allen	Johnson	Rezin	Mr. President
Ellman	Jones, E.	Rose	

The motion prevailed.

And the resolution was adopted.

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

PRESENTATION OF RESOLUTION

Senator Ellman offered the following Senate Joint Resolution and, having asked and obtained unanimous consent to suspend the rules for its immediate consideration, moved its adoption:

SENATE JOINT RESOLUTION NO. 38

RESOLVED, BY THE SENATE OF THE ONE HUNDRED FOURTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE HOUSE OF REPRESENTATIVES CONCURRING HEREIN, that when the Senate adjourns on Thursday, May 08, 2025, it stands adjourned until Tuesday, May 13, 2025,

[May 8, 2025]

or until the call of the President; and when the House of Representatives adjourns on Friday, May 09, 2025, it stands adjourned until Tuesday, May 13, 2025, or until the call of the Speaker.

The motion prevailed.

And the resolution was adopted.

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence therein.

PRESENTATION OF CELEBRATION OF LIFE RESOLUTION

SENATE RESOLUTION NO. 304

Offered by Senator Cunningham and all Senators:

Mourns the death of Thomas Patrick Hardy of Hinsdale.

By unanimous consent, the foregoing resolution was referred to the Resolutions Consent Calendar.

CELEBRATION OF LIFE RESOLUTION CONSENT CALENDAR

SENATE RESOLUTION NO. 271

Offered by Senator McClure and all Senators:

Mourns the death of Joan Rosaline Babcock of Jacksonville.

SENATE RESOLUTION NO. 272

Offered by Senator McClure and all Senators:

Mourns the death of former Illinois State Representative Charles Alphonse "Chuck" Hartke.

SENATE RESOLUTION NO. 278

Offered by Senator Rezin and all Senators:

Mourns the death of Sgt. Andrew John "Drew" Faught.

SENATE RESOLUTION NO. 279

Offered by Senator Rezin and all Senators:

Mourns the passing of Deputy Christina M. Musil of the DeKalb County Sheriff's Department.

SENATE RESOLUTION NO. 280

Offered by Senator Fowler and all Senators:

Mourns the death of James A. "Jim" Wright of Ware.

SENATE RESOLUTION NO. 281

Offered by Senator Fowler and all Senators:

Mourns the death of Ralph E. Glasford of Anna.

SENATE RESOLUTION NO. 282

Offered by Senator Fowler and all Senators:

Mourns the death of Debby Ann (Freyenberger) Tadlock of Marion, formerly of Union County.

SENATE RESOLUTION NO. 283

Offered by Senator Fowler and all Senators:

Mourns the death of Kelly Maria Nichols of Herrin.

SENATE RESOLUTION NO. 284

Offered by Senator Fowler and all Senators:

Mourns the passing of Brantly Russell Biggs.

SENATE RESOLUTION NO. 285

Offered by Senator Fowler and all Senators:
Mourns the passing of Jack Dale Glass of Metropolis.

SENATE RESOLUTION NO. 286

Offered by Senator Fowler and all Senators:
Mourns the death of John A. Guynn of Massac County.

SENATE RESOLUTION NO. 287

Offered by Senator Fowler and all Senators:
Mourns the death of Ray Edward "Bud" Bebout of Harrisburg.

SENATE RESOLUTION NO. 288

Offered by Senator Fowler and all Senators:
Mourns the passing of William Jeffrey "Jeff" Minor of Eldorado.

SENATE RESOLUTION NO. 289

Offered by Senator Fowler and all Senators:
Mourns the death of Lowell Don Powell of rural Ozark.

SENATE RESOLUTION NO. 291

Offered by Senator Anderson and all Senators:
Mourns the passing of Larry N. Varner of Kewanee, formerly of Galva.

SENATE RESOLUTION NO. 292

Offered by Senator Hastings and all Senators:
Mourns the death of Cheryl F. Green, Ph.D.

SENATE RESOLUTION NO. 293

Offered by Senator Hastings and all Senators:
Mourns the passing of Blanchie B. White Wilcox.

SENATE RESOLUTION NO. 294

Offered by Senator Rose and all Senators:
Mourns the death of Mike Behrens of Ogden.

SENATE RESOLUTION NO. 295

Offered by Senator D. Turner and all Senators:
Mourns the death of Mary Jo Copeland.

SENATE RESOLUTION NO. 296

Offered by Senator Anderson and all Senators:
Mourns the death of William Bruce "Bill" West Sr. of Hanna City.

SENATE RESOLUTION NO. 297

Offered by Senator Anderson and all Senators:
Mourns the death of Kenneth "Ken" Kaiser of Taylor Ridge.

SENATE RESOLUTION NO. 298

Offered by Senator Anderson and all Senators:
Mourns the death of Ronald Eugene "Ron" LaRoe Sr. of Bartonville.

SENATE RESOLUTION NO. 299

Offered by Senator Anderson and all Senators:
Mourns the death of Kurt "Ohlly" Oehlwein of Canton.

SENATE RESOLUTION NO. 301

Offered by Senator Koehler and all Senators:
Mourns the death of James Eugene "Jim" Kidder of Dunlap.

SENATE RESOLUTION NO. 303

Offered by Senator Anderson and all Senators:
Mourns the death of Kenneth Eugene "Kenny" McNeely.

SENATE RESOLUTION NO. 304

Offered by Senator Cunningham and all Senators:
Mourns the death of Thomas Patrick Hardy of Hinsdale.

The Chair moved the adoption of the Resolutions Consent Calendar.
The motion prevailed, and the resolutions were adopted.

LEGISLATIVE MEASURES FILED

The following Committee amendments to the House Bills listed below have been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 1 to House Bill 2387
Amendment No. 1 to House Bill 3851

At the hour of 2:03 o'clock p.m., pursuant to **Senate Joint Resolution No. 38**, the Chair announced that the Senate stands adjourned until Tuesday, May 13, 2025, at 12:00 o'clock p.m., or until the call of the President.