SENATE JOURNAL

STATE OF ILLINOIS

ONE HUNDRED FOURTH GENERAL ASSEMBLY

54TH LEGISLATIVE DAY

THURSDAY, MAY 29, 2025

2:19 O'CLOCK P.M.

NO. 54
[May 29, 2025]

SENATE
Daily Journal Index
54th Legislative Day

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The Senate met pursuant to adjournment.
Senator Omar Aquino, Chicago, Illinois, presiding.
Prayer by Reverend Jonathan Sharp, Trinity Lutheran Church, Springfield, Illinois.
Senator Johnson led the Senate in the Pledge of Allegiance.

The Journal of Tuesday, March 4, 2025, was being read when on motion of Senator Glowiak Hilton, further reading of same was dispensed with, and unless some Senator had corrections to offer, the Journal would stand approved. No corrections being offered, the Journal was ordered to stand approved.

The Journal of Wednesday, March 5, 2025, was being read when on motion of Senator Glowiak Hilton, further reading of same was dispensed with, and unless some Senator had corrections to offer, the Journal would stand approved. No corrections being offered, the Journal was ordered to stand approved.

Senator Glowiak Hilton moved that reading and approval of the Journal of Wednesday, May 28, 2025, be postponed, pending arrival of the printed Journal.
The motion prevailed.

LEGISLATIVE MEASURES FILED

The following Floor amendments to the House Bills listed below have been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 3 to House Bill 1697
Amendment No. 4 to House Bill 1697
Amendment No. 2 to House Bill 2771
Amendment No. 3 to House Bill 2785
Amendment No. 2 to House Bill 2967
Amendment No. 2 to House Bill 3019

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

Amendment No. 3 to House Bill 3363

JOINT ACTION MOTIONS FILED

The following Joint Action Motions to the Senate Bills listed below have been filed with the Secretary and referred to the Committee on Assignments:

Motion to Concur in House Amendment No. 1 to Senate Bill 314
Motion to Concur in House Amendment No. 1 to Senate Bill 1994
Motion to Concur in House Amendment No. 1 to Senate Bill 2431

REPORTS RECEIVED

The Secretary placed before the Senate the following reports:

CGFA Economic Forecast FY25 and Revenue Estimate Update FY24 Report, submitted by the Commission on Government Forecasting and Accountability.

CGFA Economic Forecast and Revenue Estimate FY26 and Revenue Update FY25 Report, submitted by the Commission on Government Forecasting and Accountability.

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

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

MESSAGES FROM THE PRESIDENT

OFFICE OF THE SENATE PRESIDENT
DON HARMON
STATE OF ILLINOIS

327 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
217-782-2728

May 29, 2025

Mr. Tim Anderson
Secretary of the Senate
Room 058 State House
Springfield, IL 62706

Dear Mr. Secretary:

Pursuant to the Senate Rule 2-10, I hereby extend the committee deadline to June 1, 2025 for the following bills:

HB850 and HB3247

Sincerely,
s/Don Harmon
Don Harmon
Senate President

cc: Senate Republican Leader John F. Curran

OFFICE OF THE SENATE PRESIDENT
DON HARMON
STATE OF ILLINOIS

327 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
217-782-2728

160 N. LASALLE ST., STE. 720
CHICAGO, ILLINOIS 60601
312-814-2075

May 29, 2025

Mr. Tim Anderson
Secretary of the Senate
Room 403 State House
Springfield, IL 62706

Dear Mr. Secretary:

Pursuant to Rule 3-2(c), I hereby appoint Senator Dave Koehler to temporarily replace Senator Kimberly A. Lightford as a member of the Senate Executive Committee. This appointment will expire upon adjournment of the Senate Executive Committee on May 29, 2025.

Sincerely,
s/Don Harmon
Don Harmon
Senate President

cc: Senate Republican Leader John F. Curran

PRESENTATION OF CELEBRATION OF LIFE RESOLUTION

SENATE RESOLUTION NO. 353

Offered by Senator Faraci and all Senators:
Mourns the death of Robert A. "Bob" Iverson of Danville.

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

PRESENTATION OF CONGRATULATORY RESOLUTION

SENATE RESOLUTION NO. 351

Offered by Senator Preston:
Congratulates Lois Preston on receiving her master's degree in computer science at the age of 87.

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

PRESENTATION OF RESOLUTION

Senator Belt offered the following Senate Resolution, which was referred to the Committee on Assignments:

SENATE RESOLUTION NO. 352

WHEREAS, The Paul Simon Public Policy Institute at Southern Illinois University Carbondale is a nonprofit, nonpartisan think tank dedicated to promoting better politics and smarter government, while preparing young people for careers in public service; and

WHEREAS, The Paul Simon Public Policy Institute provides internships that offer students real-world experience and knowledge in public service, as well as in their field of interest; Dr. Linda Renee Baker has served as the director of these internships for over 10 years, providing mentorship, leadership, and guidance to students pursuing careers in public service; these internships include the Alexander Lane Internship, the Barb Brown Internship, the Gene Callahan Internship, the Latino Heritage Internship, the Social Work Internship, and the Vince Demuzio Internship; interns work closely with their placement offices to aid in research, office support, and programming; and

WHEREAS, The Paul Simon Public Policy Institute offers a variety of scholarships annually, including the Barb Brown Memorial Scholarship, the David Yepsen Director's Award, the Edwin D. Phillips Debate Team Scholarship, the Jeanne Hurley Simon Memorial Scholarship, the Mike Lawrence Scholarship, and the Matt Baughman Scholarship to support and recognize outstanding students; and

WHEREAS, Women's Civic Day is one of the Paul Simon Public Policy Institute's annual initiatives, bringing women students from Southern Illinois University to the Illinois Capitol Building to promote the

contributions of women legislators and public sector leaders and to encourage the continued development of women's leadership and involvement in public affairs; and

WHEREAS, Women's Civic Day serves to highlight the contributions of women to public service in Illinois and inspire future engagement by providing students with the opportunity to hear from a variety of speakers, including legislators, public sector leaders, and community coordinators during a one-day event typically held in the spring at the Illinois Capitol Building in Springfield; and

WHEREAS, The success of the 2025 Women's Civic Day would not have been possible without the leadership of Dr. Linda Renee Baker and the dedication of the Paul Simon Public Policy Institute's current interns and fellow, including Traseanda Jones (2025 Alexander Lane Intern), Journey Short (2025 Gene Callahan Intern), Brandon Varela (2025 Latino Heritage Intern), Rachel Wilson (2025 Social Work Intern), and Macy Sanchez (2025 Celia M. Howard Fellow), each of whom played an integral role in organizing and supporting this year's program; and

WHEREAS, The 2025 Women's Civic Day welcomed and celebrated the participation of outstanding Southern Illinois University students, including Lily Bishop, Cheyanne Bristol, Elisa Tatiana, Myla Croft, Jayme Ferris, Jessica Hardges, Amber Koteras, Jenny Leyva Castro, Autumn Montague, Nadia Ogiele, Justyce Petty, Macy Sanchez, RyAnn Clark, Hannah Connolly, Olivia Drew, Raylynn Elder, Audrey Gulley, and Lora Judge, each of whom demonstrated a commitment to civic engagement, leadership, and public service; therefore, be it

RESOLVED, BY THE SENATE OF THE ONE HUNDRED FOURTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that we declare March 19, 2025 as Women's Civic Day to celebrate and promote the vital role of women in public service and encourage the development of future women leaders in public affairs; and be it further

RESOLVED, That a suitable copy of this resolution be presented to the Paul Simon Public Policy Institute as a symbol of our respect and esteem.

REPORTS FROM STANDING COMMITTEES

Senator D. Turner, Chair of the Committee on Agriculture, to which was referred the Motions to Concur with House Amendments to the following Senate Bills, reported that the Committee recommends do adopt:

Motion to Concur in House Amendment No. 1 to Senate Bill 2455; Motion to Concur in House Amendment No. 1 to Senate Bill 2459

Under the rules, the foregoing motions are eligible for consideration by the Senate.

Senator Stadelman, Chair of the Committee on Energy and Public Utilities, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

Senate Amendment No. 1 to House Bill 2435

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

Senator Ellman, Chair of the Committee on Environment and Conservation, to which was referred the Motions to Concur with House Amendments to the following Senate Bills, reported that the Committee recommends do adopt:

Motion to Concur in House Amendment No. 1 to Senate Bill 1859; Motion to Concur in House Amendment No. 1 to Senate Bill 2466

Under the rules, the foregoing motions are eligible for consideration by the Senate.

MESSAGE FROM THE HOUSE

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has passed bills of the following titles, in the passage of which I am instructed to ask the concurrence of the Senate, to-wit:

HOUSE BILL NO. 111

A bill for AN ACT making appropriations.

HOUSE BILL NO. 1582

A bill for AN ACT concerning finance.
Passed the House, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

The foregoing **House Bills Numbered 111 and 1582** were taken up, ordered printed and placed on first reading.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A FIRST TIME

House Bill No. 111, sponsored by Senator Harmon, was taken up, read by title a first time and referred to the Committee on Assignments.

House Bill No. 1582, sponsored by Senator Martwick, was taken up, read by title a first time and referred to the Committee on Assignments.

Senator Holmes asked and obtained unanimous consent to recess for the purpose of a Democrat caucus.

Senator McClure asked and obtained unanimous consent to recess for the purpose of a Republican caucus.

At the hour of 2:49 o'clock p.m., the Chair announced that the Senate stands at recess subject to the call of the Chair.

AFTER RECESS

At the hour of 4:22 o'clock p.m., the Senate resumed consideration of business.
Senator Aquino, presiding.

READING BILL OF THE SENATE A SECOND TIME

On motion of Senator Belt, **Senate Bill No. 1855** having been printed, was taken up, read by title a second time.
The following amendment was offered in the Committee on Executive, adopted and ordered printed:

AMENDMENT NO. 1 TO SENATE BILL 1855

AMENDMENT NO. 1 . Amend Senate Bill 1855 by replacing everything after the enacting clause with the following:

"Section 5. The Counties Code is amended by adding Section 5-5002 as follows:
(55 ILCS 5/5-5002 new)
Sec. 5-5002. Outside law enforcement compensation. A county shall reimburse a law enforcement agency, as defined by the Illinois Police Training Act, for public safety services provided by that law enforcement agency if (i) the county has or has had a law enforcement agency and (ii) the county either ceases to provide law enforcement services for that incorporated area or substantially reduces the amount of law enforcement services provided for that incorporated area. A law enforcement agency shall conduct a cost-analysis study for public services that the law enforcement agency provided to the county for determining the amount to be reimbursed.

Section 10. The Township Code is amended by adding Section 85-70 as follows:
(60 ILCS 1/85-70 new)
Sec. 85-70. Outside law enforcement compensation. A township shall reimburse a law enforcement agency, as defined by the Illinois Police Training Act, for public safety services provided by that law enforcement agency if (i) the township has or has had a law enforcement agency and (ii) the township either ceases to provide law enforcement services for that incorporated area or substantially reduces the amount of law enforcement services provided for that incorporated area. A law enforcement agency shall conduct a cost-analysis study for public services that the law enforcement agency provided to the township for determining the amount to be reimbursed.

Section 15. The Illinois Municipal Code is amended by adding Section 11-1-11.5 as follows:
(65 ILCS 5/11-1-11.5 new)
Sec. 11-1-11.5. Outside law enforcement compensation. A municipality shall reimburse a law enforcement agency, as defined by the Illinois Police Training Act, for public safety services provided by that law enforcement agency if (i) the municipality has or has had a law enforcement agency and (ii) the municipality either ceases to provide law enforcement services for that incorporated area or substantially reduces the amount of law enforcement services provided for that incorporated area. A law enforcement agency shall conduct a cost-analysis study for public services that the law enforcement agency provided to the municipality for determining the amount to be reimbursed.".

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 Villanueva, **House Bill No. 460** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Preston, **House Bill No. 1224** having been printed, was taken up and read by title a second time.
The following amendment was offered in the Committee on Executive, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 1224
AMENDMENT NO. 1 . Amend House Bill 1224 by replacing everything after the enacting clause with the following:

"Section 5. The Public Construction Bond Act is amended by changing Section 1 as follows:
(30 ILCS 550/1) (from Ch. 29, par. 15)
Sec. 1. Except as otherwise provided by this Act, until January 1, 2029, all officials, boards, commissions, or agents of this State, or of any political subdivision thereof, in making contracts for public work of any kind costing over $150,000 to be performed for the State, or of any political subdivision thereof, shall require every contractor for the work to furnish, supply and deliver a bond to the State, or to the political subdivision thereof entering into the contract, as the case may be, with good and sufficient sureties. The surety on the bond shall be a company that is licensed by the Department of Insurance

authorizing it to execute surety bonds and the company shall have a financial strength rating of at least A- as rated by A.M. Best Company, Inc., Moody's Investors Service, Standard & Poor's Corporation, or a similar rating agency. The amount of the bond shall be fixed by the officials, boards, commissions, commissioners or agents, and the bond, among other conditions, shall be conditioned for the completion of the contract, for the payment of material, apparatus, fixtures, and machinery used in the work and for all labor performed in the work, whether by subcontractor or otherwise.

Until January 1, 2029, when making contracts for public works to be constructed, the Department of Transportation and the Illinois State Toll Highway Authority shall require every contractor for those works to furnish, supply, and deliver a bond to the Department or the Authority, as the case may be, with good and sufficient sureties only if the public works contract will cost more than $500,000. The Department of Transportation and the Illinois State Toll Highway Authority shall publicly display the following information by website or annual report and shall provide that information to interested parties upon request:

(1) a list of each of its defaulted public works contracts, including the value of the award, the adjusted contract value, and the amount remaining unpaid by the Department or Authority, as applicable;

(2) the number and the aggregate amount of payment claims made under the Mechanics Lien Act along with the number of contracts in which payment claims are made under the Mechanics Lien Act;

(3) for each of its public improvement contracts, regardless of the contract value, the aggregate annual revenue of the contractor derived from contracts with the State;

(4) for each of its public works contracts, regardless of contract value, the identity of the surety providing the contract bond, payment and performance bond, or both; and

(5) for each of its public works contracts, regardless of the bond threshold, a list of bidders for each public works contract, and the amount bid by each bidder.

Until January 1, 2029, local governmental units may require a bond, by ordinance or resolution, for public works contracts valued at $150,000 or less.

On and after January 1, 2029, all officials, boards, commissions, or agents of this State, or of any political subdivision thereof, in making contracts for public work of any kind costing over $50,000 to be performed for the State, or of any political subdivision thereof, shall require every contractor for the work to furnish, supply and deliver a bond to the State, or to the political subdivision thereof entering into the contract, as the case may be, with good and sufficient sureties. The surety on the bond shall be a company that is licensed by the Department of Insurance authorizing it to execute surety bonds and the company shall have a financial strength rating of at least A- as rated by A.M. Best Company, Inc., Moody's Investors Service, Standard & Poor's Corporation, or a similar rating agency. The amount of the bond shall be fixed by the officials, boards, commissions, commissioners or agents, and the bond, among other conditions, shall be conditioned for the completion of the contract, for the payment of material, apparatus, fixtures, and machinery used in the work and for all labor performed in the work, whether by subcontractor or otherwise.

If the contract is for emergency repairs as provided in the Illinois Procurement Code, proof of payment for all labor, materials, apparatus, fixtures, and machinery may be furnished in lieu of the bond required by this Section.

Each such bond is deemed to contain the following provisions whether such provisions are inserted in such bond or not:

"The principal and sureties on this bond agree that all the undertakings, covenants, terms, conditions and agreements of the contract or contracts entered into between the principal and the State or any political subdivision thereof will be performed and fulfilled and to pay all persons, firms and corporations having contracts with the principal or with subcontractors, all just claims due them under the provisions of such contracts for labor performed or materials furnished in the performance of the contract on account of which this bond is given, when such claims are not satisfied out of the contract price of the contract on account of which this bond is given, after final settlement between the officer, board, commission or agent of the State or of any political subdivision thereof and the principal has been made.".

Each bond securing contracts between the Capital Development Board or any board of a public institution of higher education and a contractor shall contain the following provisions, whether the provisions are inserted in the bond or not:

"Upon the default of the principal with respect to undertakings, covenants, terms, conditions, and agreements, the termination of the contractor's right to proceed with the work, and written notice of that

default and termination by the State or any political subdivision to the surety ("Notice"), the surety shall promptly remedy the default by taking one of the following actions:

(1) The surety shall complete the work pursuant to a written takeover agreement, using a completing contractor jointly selected by the surety and the State or any political subdivision; or

(2) The surety shall pay a sum of money to the obligee, up to the penal sum of the bond, that represents the reasonable cost to complete the work that exceeds the unpaid balance of the contract sum.

The surety shall respond to the Notice within 15 working days of receipt indicating the course of action that it intends to take or advising that it requires more time to investigate the default and select a course of action. If the surety requires more than 15 working days to investigate the default and select a course of action or if the surety elects to complete the work with a completing contractor that is not prepared to commence performance within 15 working days after receipt of Notice, and if the State or any political subdivision determines it is in the best interest of the State to maintain the progress of the work, the State or any political subdivision may continue to work until the completing contractor is prepared to commence performance. Unless otherwise agreed to by the procuring agency, in no case may the surety take longer than 30 working days to advise the State or political subdivision on the course of action it intends to take. The surety shall be liable for reasonable costs incurred by the State or any political subdivision to maintain the progress to the extent the costs exceed the unpaid balance of the contract sum, subject to the penal sum of the bond.".

The surety bond required by this Section may be acquired from the company, agent or broker of the contractor's choice. The bond and sureties shall be subject to the right of reasonable approval or disapproval, including suspension, by the State or political subdivision thereof concerned. Except as otherwise provided in this Section, in the case of State construction contracts, a contractor shall not be required to post a cash bond or letter of credit in addition to or as a substitute for the surety bond required by this Section.

Prior to the completion of 50% of the contract for public works, the State or a local governmental unit, except for the Department of Transportation, may not withhold retainage from any payment to a contractor who furnishes the bond or bond substitute required by this Act in an amount in excess of 10% of any payment made prior to the date of completion of 50% of the contract for public works. When a contract for public works is 50% complete, the State or the local governmental unit, except for the Department of Transportation, shall reduce the retainage so that no more than 5% is held. After the contract is 50% complete, no more than 5% of the amount of any subsequent payments made under the contract for public works may be withheld as retainage.

Subject to the limitations in this Section, a State agency may withhold as retainage a portion of the moneys from the payment of a contract that is entered into on or after the effective date of this amendatory Act of the 104th General Assembly if and only if the State agency determines that satisfactory progress has not been achieved by a contractor or subcontractor during any period for which a payment is to be made. Satisfactory progress shall be clearly provided for in the contract between the State agency and the contractor or subcontractor. Retainage may not be used as a substitute for good contract management, and the State agency may not withhold funds without cause. Determinations to retain and the specific amount to be withheld must be made by the State agency on a case-by-case basis based on the performance of milestones under the current contract as provided for in the contract between the State agency and the contractor. A contractor may not withhold retainage from a subcontractor except to the extent a State agency has withheld retainage from the contractor which is attributable to that subcontractor's subcontract.

Prior to the completion of 50% of the contract for public works, the contractor and their respective subcontractors shall not withhold from their subcontractors retainage in excess of 10% of any payment made prior to the date of completion of 50% of the contract for public works. When the contract for public works is 50% complete, the contractor and its subcontractors shall reduce the retainage so that no more than 5% is withheld from their respective subcontractors. After the contract is 50% complete, the contractor and its subcontractors shall not withhold more than 5% of the amount of any subsequent payments made under the contract to their respective subcontractors.

When other than motor fuel tax funds, federal-aid funds, or other funds received from the State are used, a political subdivision may allow the contractor to provide a non-diminishing irrevocable bank letter of credit, in lieu of the bond required by this Section, on contracts under $100,000 to comply with the requirements of this Section. Any such bank letter of credit shall contain all provisions required for bonds by this Section.

In order to reduce barriers to entry for diverse and small businesses, the Department of Transportation may implement a 5-year pilot program to allow a contractor to provide a non-diminishing irrevocable bank letter of credit in lieu of the bond required by this Section on contracts under $500,000. Projects selected by the Department of Transportation for this pilot program must be classified by the Department as low-risk scope of work contracts. The Department shall adopt rules to define the criteria for pilot project selection and implementation of the pilot program.

In this Section:

"Local governmental unit" has the meaning ascribed to it in Section 2 of the Local Government Prompt Payment Act.

"Material", "labor", "apparatus", "fixtures", and "machinery" include those rented items that are on the construction site and those rented tools that are used or consumed on the construction site in the performance of the contract on account of which the bond is given.

"Retainage" means a portion of money withheld from a payment, including, but not limited to, a payment as defined in the Local Government Prompt Payment Act or the State Prompt Payment Act, made to a contractor or subcontractor intended to ensure that the contractor or subcontractor completes the requirements of the contract or subcontract. "Retainage" does not include (i) moneys withheld due to violations of local, State, or federal laws or (ii) moneys withheld from grants to entities for capital improvements to non-State property.

Nothing in this amendatory Act of the 104th General Assembly may be construed to modify any provision of the State Prompt Payment Act or the Local Government Prompt Payment Act.

(Source: P.A. 102-968, eff. 1-1-23; 103-570, eff. 1-1-24.)

Section 99. Effective date. This Act takes effect June 1, 2027.".

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

On motion of Senator E. Harriss, **House Bill No. 2155** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Murphy, **House Bill No. 3339** having been printed, was taken up and read by title a second time.

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

AMENDMENT NO. 1 TO HOUSE BILL 3339

AMENDMENT NO. 1 . Amend House Bill 3339 on page 9, by replacing lines 6 and 7 with "an ALPR. This subsection (fff) is inoperative on and after July 1, 2028 ~~2025~~.".

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

READING BILL OF THE SENATE A SECOND TIME

On motion of Senator Joyce, **Senate Bill No. 1473** having been printed, was taken up, read by title a second time.

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

AMENDMENT NO. 1 TO SENATE BILL 1473

AMENDMENT NO. 1 . Amend Senate Bill 1473 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Income Tax Act is amended by adding Section 252 as follows:

(35 ILCS 5/252 new)

Sec. 252. Backstretch assistance tax credit.

(a) For taxable years ending on or after December 31, 2025 and ending on or before December 31, 2030, each taxpayer that is an organization gaming licensee under the Illinois Horse Racing Act of 1975 is entitled to a credit against the taxes imposed by subsections (a) and (b) of Section 201 in an amount up to

$5,000,000 for qualified project capital infrastructure improvements for housing and other facilities that benefit backstretch workers at an organization gaming licensee facility operating on May 1, 2025. No taxpayer may claim more than $5,000,000 in the aggregate for taxable years ending on or after December 31, 2025 and ending on or before December 31, 2030.

(b) If the taxpayer is a partnership or Subchapter S corporation, the credit is allowed to pass through to the partners and shareholders as provided in Section 251. Credits may also be transferred during the 5 taxable years after the taxable year in which the credit is claimed.

(c) The Department shall determine whether a project qualifies for the credit under this Section based on whether it includes improvements for backstretch workers and facilities that benefit the backstretch workers.

(d) Project costs shall not include the organization gaming licensee's organization gaming facility or other property not related to housing and other facilities that benefit backstretch workers.

(e) The Department shall adopt rules to implement and administer this Section, including rules concerning applications for the tax credit. A taxpayer claiming the credit provided by this Section must maintain and record any information that the Department requires regarding the project for which the credit is claimed.

Section 10. The Illinois Horse Racing Act of 1975 is amended by changing Sections 19, 19.5, 20, and 26 and by adding Section 19.10 as follows:

(230 ILCS 5/19) (from Ch. 8, par. 37-19)

Sec. 19. (a) No organization license may be granted to conduct a horse race meeting:

(1) except as provided in subsection (c) of Section 21 of this Act, to any person at any place within 35 miles of any other place licensed by the Board to hold a race meeting on the same date during the same hours; ~~,~~ the mileage measurement used in this paragraph (1) ~~subsection (a)~~ shall be certified to the Board by the Bureau of Systems and Services in the Illinois Department of Transportation as the most commonly used public way of vehicular travel;

(1.5) except as provided in Section 19.10 of this Act, to any person at any place within 100 miles of a track located in a county with a population in excess of 230,000 and that borders the Mississippi River; the mileage measurement used in this paragraph (1.5) shall be certified to the Board by the Bureau of Systems and Services at the Illinois Department of Transportation as the most commonly used public way of vehicular travel; this paragraph (1.5) shall not apply to a licensed race meeting conducted by an organization licensee at the Springfield State fairgrounds;

(2) to any person in default in the payment of any obligation or debt due the State under this Act, provided no applicant shall be deemed in default in the payment of any obligation or debt due to the State under this Act as long as there is pending a hearing of any kind relevant to such matter;

(3) to any person who has been convicted of the violation of any law of the United States or any State law which provided as all or part of its penalty imprisonment in any penal institution; to any person against whom there is pending a Federal or State criminal charge; to any person who is or has been connected with or engaged in the operation of any illegal business; to any person who does not enjoy a general reputation in his community of being an honest, upright, law-abiding person; provided that none of the matters set forth in this subparagraph (3) shall make any person ineligible to be granted an organization license if the Board determines, based on circumstances of any such case, that the granting of a license would not be detrimental to the interests of horse racing and of the public;

(4) to any person who does not at the time of application for the organization license own or have a contract or lease for the possession of a finished race track suitable for the type of racing intended to be held by the applicant and for the accommodation of the public.

(b) (Blank).

(c) If any person is ineligible to receive an organization license because of any of the matters set forth in subsection (a) (2) or subsection (a) (3) of this Section, any other or separate person that either (i) controls, directly or indirectly, such ineligible person or (ii) is controlled, directly or indirectly, by such ineligible person or by a person which controls, directly or indirectly, such ineligible person shall also be ineligible.

(Source: P.A. 101-31, eff. 6-28-19.)

(230 ILCS 5/19.5)

Sec. 19.5. Standardbred racetrack in Cook County. Notwithstanding anything in this Act to the contrary, in addition to organization licenses issued by the Board on the effective date of this amendatory Act of the 101st General Assembly, the Board shall issue an organization license limited to standardbred

racing to a racetrack located in one of the following townships of Cook County: Bloom, Bremen, Calumet, Orland, Rich, Thornton, or Worth. This additional organization license shall not be issued within a 35-mile radius of another organization license issued by the Board on the effective date of this amendatory Act of the 101st General Assembly, unless the person having operating control of such racetrack has given written consent to the organization licensee applicant, which consent must be filed with the Board at or prior to the time application is made. However, the consent required by this Section from the person having operating control of such racetrack shall not be required after December 31, 2025. The organization license application shall be submitted to the Board and the Board may grant the organization license at any meeting of the Board. The Board shall examine the application within 21 days after receipt of the application with respect to its conformity with this Act and the rules adopted by the Board. If the application does not comply with this Act or the rules adopted by the Board, the application may be rejected and an organization license refused to the applicant, or the Board may, within 21 days after receipt of the application, advise the applicant of the deficiencies of the application under the Act or the rules of the Board and require the submittal of an amended application within a reasonable time determined by the Board; upon submittal of the amended application by the applicant, the Board may consider the application consistent with the process described in subsection (e-5) of Section 20. If the application is found to be in compliance with this Act and the rules of the Board, the Board shall then issue an organization license to the applicant. Once the organization license is granted, the licensee shall have all of the current and future rights of existing Illinois racetracks, including, but not limited to, the ability to obtain an inter-track wagering license, the ability to obtain inter-track wagering location licenses, the ability to obtain an organization gaming license pursuant to the Illinois Gambling Act with 1,200 gaming positions, and the ability to offer Internet wagering on horse racing.

(Source: P.A. 101-31, eff. 6-28-19; 102-689, eff. 12-17-21.)

(230 ILCS 5/19.10 new)

Sec. 19.10. Standardbred racetrack in Macon County. Notwithstanding anything in this Act to the contrary, in addition to organization licenses issued by the Board on the effective date of this amendatory Act of the 104th General Assembly, the Board shall issue an organization license limited to standardbred racing to a racetrack located in Macon County. Any physical gaming positions issued to an organization licensee under this Section that also receives organization gaming licensee under Section 56 shall be located in Macon County. The organization license application shall be submitted to the Board and the Board may grant the organization license at any meeting of the Board. The Board shall examine the application within 21 days after receipt of the application with respect to its conformity with this Act and the rules adopted by the Board. If the application does not comply with this Act or the rules adopted by the Board, the application may be rejected and an organization license refused to the applicant, or the Board may, within 21 days after receipt of the application, advise the applicant of the deficiencies of the application under this Act or the rules of the Board and require the submittal of an amended application within a reasonable time determined by the Board. Upon submittal of the amended application by the applicant, the Board may consider the application consistent with the process described in subsection (e-5) of Section 20. If the application is found to be in compliance with this Act and the rules of the Board, the Board shall then issue an organization license to the applicant. Once the organization license is granted, the licensee shall have all of the current and future rights of existing Illinois racetracks, including, but not limited to, the ability to obtain an inter-track wagering license, the ability to obtain inter-track wagering location licenses, the ability to obtain an organization gaming license pursuant to the Illinois Gambling Act with 900 gaming positions, and the ability to offer Internet wagering on horse racing.

(230 ILCS 5/20) (from Ch. 8, par. 37-20)

Sec. 20. (a) Any person desiring to conduct a horse race meeting may apply to the Board for an organization license. The application shall be made on a form prescribed and furnished by the Board. The application shall specify:

(1) the dates on which it intends to conduct the horse race meeting, which dates shall be provided under Section 21;

(2) the hours of each racing day between which it intends to hold or conduct horse racing at such meeting;

(3) the location where it proposes to conduct the meeting; and

(4) any other information the Board may reasonably require.

(b) A separate application for an organization license shall be filed for each horse race meeting which such person proposes to hold. Any such application, if made by an individual, or by any individual as

trustee, shall be signed and verified under oath by such individual. If the application is made by individuals, then it shall be signed and verified under oath by at least 2 of the individuals; if the application is made by a partnership, an association, a corporation, a corporate trustee, a limited liability company, or any other entity, it shall be signed by an authorized officer, a partner, a member, or a manager, as the case may be, of the entity.

(c) The application shall specify:

(1) the name of the persons, association, trust, or corporation making such application;

(2) the principal address of the applicant;

(3) if the applicant is a trustee, the names and addresses of the beneficiaries; if the applicant is a corporation, the names and addresses of all officers, stockholders and directors; or if such stockholders hold stock as a nominee or fiduciary, the names and addresses of the parties who are the beneficial owners thereof or who are beneficially interested therein; if the applicant is a partnership, the names and addresses of all partners, general or limited; if the applicant is a limited liability company, the names and addresses of the manager and members; and if the applicant is any other entity, the names and addresses of all officers or other authorized persons of the entity.

(d) The applicant shall execute and file with the Board a good faith affirmative action plan to recruit, train, and upgrade minorities in all classifications within the association.

(e) With such application there shall be delivered to the Board a certified check or bank draft payable to the order of the Board for an amount equal to $1,000. All applications for the issuance of an organization license shall be filed with the Board before August 1 of the year prior to the year for which application is made and shall be acted upon by the Board at a meeting to be held on such date as shall be fixed by the Board during the last 15 days of September of such prior year. At such meeting, the Board shall announce the award of the racing meets, live racing schedule, and designation of host track to the applicants and its approval or disapproval of each application. No announcement shall be considered binding until a formal order is executed by the Board, which shall be executed no later than October 15 of that prior year. Absent the agreement of the affected organization licensees, the Board shall not grant overlapping race meetings to 2 or more tracks that are within 100 miles of each other to conduct the thoroughbred racing.

(e-1) The Board shall award standardbred racing dates to organization licensees with an organization gaming license pursuant to the following schedule:

(1) For the first calendar year of operation of gambling games by an organization gaming licensee under this amendatory Act of the 101st General Assembly, when a single entity requests standardbred racing dates, the Board shall award no fewer than 100 days of racing. The 100-day requirement may be reduced to no fewer than 80 days if no dates are requested for the first 3 months of a calendar year. If more than one entity requests standardbred racing dates, the Board shall award no fewer than 140 days of racing between the applicants.

(2) For the second calendar year of operation of gambling games by an organization gaming licensee under this amendatory Act of the 101st General Assembly, when a single entity requests standardbred racing dates, the Board shall award no fewer than 100 days of racing. The 100-day requirement may be reduced to no fewer than 80 days if no dates are requested for the first 3 months of a calendar year. If more than one entity requests standardbred racing dates, the Board shall award no fewer than 160 days of racing between the applicants.

(3) For the third calendar year of operation of gambling games by an organization gaming licensee under this amendatory Act of the 101st General Assembly, and each calendar year thereafter, when a single entity requests standardbred racing dates, the Board shall award no fewer than 120 days of racing. The 120-day requirement may be reduced to no fewer than 100 days if no dates are requested for the first 3 months of a calendar year. If more than one entity requests standardbred racing dates, the Board shall award no fewer than 200 days of racing between the applicants.

(4) Notwithstanding any other requirement of this subsection, if the Board approves an organization license pursuant to Section 19.10, the Board may award fewer than the minimum number of racing days, but no fewer than 60 days of racing, if there is consent for fewer days of racing as agreed to by the organization licensee and the horsemen association representing the largest number of owners, trainers, jockeys, or standardbred drivers who race horses at that organization licensee's racing meeting.

(5) Notwithstanding any other requirement of this subsection, if the Board approves an organization license pursuant to Section 19.10 before July 1, 2025, and the organization licensee applies for racing days in the remainder of 2025, the Board may award racing days to the organization

licensee in the remainder of 2025 after the Board has considered the application consistent with subsection (e-5).

An organization licensee shall apply for racing dates pursuant to this subsection (e-1). In awarding racing dates under this subsection (e-1), the Board shall have the discretion to allocate those standardbred racing dates among these organization licensees.

(e-2) The Board shall award thoroughbred racing days to Cook County organization licensees pursuant to the following schedule:

(1) During the first year in which only one organization licensee is awarded an organization gaming license, the Board shall award no fewer than 110 days of racing.

During the second year in which only one organization licensee is awarded an organization gaming license, the Board shall award no fewer than 115 racing days.

During the third year and every year thereafter, in which only one organization licensee is awarded an organization gaming license, the Board shall award no fewer than 120 racing days.

(2) During the first year in which 2 organization licensees are awarded an organization gaming license, the Board shall award no fewer than 139 total racing days.

During the second year in which 2 organization licensees are awarded an organization gaming license, the Board shall award no fewer than 160 total racing days.

During the third year and every year thereafter in which 2 organization licensees are awarded an organization gaming license, the Board shall award no fewer than 174 total racing days.

A Cook County organization licensee shall apply for racing dates pursuant to this subsection (e-2). In awarding racing dates under this subsection (e-2), the Board shall have the discretion to allocate those thoroughbred racing dates among these Cook County organization licensees.

(e-3) In awarding racing dates for calendar year 2020 and thereafter in connection with a racetrack in Madison County, the Board shall award racing dates and such organization licensee shall run at least 700 thoroughbred races at the racetrack in Madison County each year.

Notwithstanding Section 7.7 of the Illinois Gambling Act or any provision of this Act other than subsection (e-4.5), for each calendar year for which an organization gaming licensee located in Madison County requests racing dates resulting in less than 700 live thoroughbred races at its racetrack facility, the organization gaming licensee may not conduct gaming pursuant to an organization gaming license issued under the Illinois Gambling Act for the calendar year of such requested live races.

(e-4) Notwithstanding the provisions of Section 7.7 of the Illinois Gambling Act or any provision of this Act other than subsections (e-3) and (e-4.5), for each calendar year for which an organization gaming licensee requests thoroughbred racing dates which results in a number of live races under its organization license that is less than the total number of live races which it conducted in 2017 at its racetrack facility, the organization gaming licensee may not conduct gaming pursuant to its organization gaming license for the calendar year of such requested live races.

(e-4.1) Notwithstanding the provisions of Section 7.7 of the Illinois Gambling Act or any provision of this Act other than subsections (e-3) and (e-4.5), for each calendar year for which an organization licensee requests racing dates for standardbred racing which results in a number of live races that is less than the total number of live races required in subsection (e-1), the organization gaming licensee may not conduct gaming pursuant to its organization gaming license for the calendar year of such requested live races.

(e-4.5) The Board shall award the minimum live racing guarantees contained in subsections (e-1), (e-2), and (e-3) to ensure that each organization licensee shall individually run a sufficient number of races per year to qualify for an organization gaming license under this Act. The General Assembly finds that the minimum live racing guarantees contained in subsections (e-1), (e-2), and (e-3) are in the best interest of the sport of horse racing, and that such guarantees may only be reduced in the calendar year in which they will be conducted in the limited circumstances described in this subsection. The Board may decrease the number of racing days without affecting an organization licensee's ability to conduct gaming pursuant to an organization gaming license issued under the Illinois Gambling Act only if the Board determines, after notice and hearing, that:

(i) a decrease is necessary to maintain a sufficient number of betting interests per race to ensure the integrity of racing;

(ii) there are unsafe track conditions due to weather or acts of God;

(iii) there is an agreement between an organization licensee and the breed association that is applicable to the involved live racing guarantee, such association representing either the largest number of thoroughbred owners and trainers or the largest number of standardbred owners, trainers

and drivers who race horses at the involved organization licensee's racing meeting, so long as the agreement does not compromise the integrity of the sport of horse racing; or

(iv) the horse population or purse levels are insufficient to provide the number of racing opportunities otherwise required in this Act.

In decreasing the number of racing dates in accordance with this subsection, the Board shall hold a hearing and shall provide the public and all interested parties notice and an opportunity to be heard. The Board shall accept testimony from all interested parties, including any association representing owners, trainers, jockeys, or drivers who will be affected by the decrease in racing dates. The Board shall provide a written explanation of the reasons for the decrease and the Board's findings. The written explanation shall include a listing and content of all communication between any party and any Illinois Racing Board member or staff that does not take place at a public meeting of the Board.

(e-5) In reviewing an application for the purpose of granting an organization license consistent with the best interests of the public and the sport of horse racing, the Board shall consider:

(1) the character, reputation, experience, and financial integrity of the applicant and of any other separate person that either:

(i) controls the applicant, directly or indirectly, or

(ii) is controlled, directly or indirectly, by that applicant or by a person who controls, directly or indirectly, that applicant;

(2) the applicant's facilities or proposed facilities for conducting horse racing;

(3) the total revenue without regard to Section 32.1 to be derived by the State and horsemen from the applicant's conducting a race meeting;

(4) the applicant's good faith affirmative action plan to recruit, train, and upgrade minorities in all employment classifications;

(5) the applicant's financial ability to purchase and maintain adequate liability and casualty insurance;

(6) the applicant's proposed and prior year's promotional and marketing activities and expenditures of the applicant associated with those activities;

(7) an agreement, if any, among organization licensees as provided in subsection (b) of Section 21 of this Act; and

(8) the extent to which the applicant exceeds or meets other standards for the issuance of an organization license that the Board shall adopt by rule.

In granting organization licenses and allocating dates for horse race meetings, the Board shall have discretion to determine an overall schedule, including required simulcasts of Illinois races by host tracks that will, in its judgment, be conducive to the best interests of the public and the sport of horse racing.

(e-10) The Illinois Administrative Procedure Act shall apply to administrative procedures of the Board under this Act for the granting of an organization license, except that (1) notwithstanding the provisions of subsection (b) of Section 10-40 of the Illinois Administrative Procedure Act regarding cross-examination, the Board may prescribe rules limiting the right of an applicant or participant in any proceeding to award an organization license to conduct cross-examination of witnesses at that proceeding where that cross-examination would unduly obstruct the timely award of an organization license under subsection (e) of Section 20 of this Act; (2) the provisions of Section 10-45 of the Illinois Administrative Procedure Act regarding proposals for decision are excluded under this Act; (3) notwithstanding the provisions of subsection (a) of Section 10-60 of the Illinois Administrative Procedure Act regarding ex parte communications, the Board may prescribe rules allowing ex parte communications with applicants or participants in a proceeding to award an organization license where conducting those communications would be in the best interest of racing, provided all those communications are made part of the record of that proceeding pursuant to subsection (c) of Section 10-60 of the Illinois Administrative Procedure Act; (4) the provisions of Section 14a of this Act and the rules of the Board promulgated under that Section shall apply instead of the provisions of Article 10 of the Illinois Administrative Procedure Act regarding administrative law judges; and (5) the provisions of subsection (d) of Section 10-65 of the Illinois Administrative Procedure Act that prevent summary suspension of a license pending revocation or other action shall not apply.

(f) The Board may allot racing dates to an organization licensee for more than one calendar year but for no more than 3 successive calendar years in advance, provided that the Board shall review such allotment for more than one calendar year prior to each year for which such allotment has been made. The granting of an organization license to a person constitutes a privilege to conduct a horse race meeting under

the provisions of this Act, and no person granted an organization license shall be deemed to have a vested interest, property right, or future expectation to receive an organization license in any subsequent year as a result of the granting of an organization license. Organization licenses shall be subject to revocation if the organization licensee has violated any provision of this Act or the rules and regulations promulgated under this Act or has been convicted of a crime or has failed to disclose or has stated falsely any information called for in the application for an organization license. Any organization license revocation proceeding shall be in accordance with Section 16 regarding suspension and revocation of occupation licenses.

(f-5) If, (i) an applicant does not file an acceptance of the racing dates awarded by the Board as required under part (1) of subsection (h) of this Section 20, or (ii) an organization licensee has its license suspended or revoked under this Act, the Board, upon conducting an emergency hearing as provided for in this Act, may reaward on an emergency basis pursuant to rules established by the Board, racing dates not accepted or the racing dates associated with any suspension or revocation period to one or more organization licensees, new applicants, or any combination thereof, upon terms and conditions that the Board determines are in the best interest of racing, provided, the organization licensees or new applicants receiving the awarded racing dates file an acceptance of those reawarded racing dates as required under paragraph (1) of subsection (h) of this Section 20 and comply with the other provisions of this Act. The Illinois Administrative Procedure Act shall not apply to the administrative procedures of the Board in conducting the emergency hearing and the reallocation of racing dates on an emergency basis.

(g) (Blank).

(h) The Board shall send the applicant a copy of its formally executed order by certified mail addressed to the applicant at the address stated in his application, which notice shall be mailed within 5 days of the date the formal order is executed.

Each applicant notified shall, within 10 days after receipt of the final executed order of the Board awarding racing dates:

(1) file with the Board an acceptance of such award in the form prescribed by the Board;

(2) pay to the Board an additional amount equal to $110 for each racing date awarded; and

(3) file with the Board the bonds required in Sections 21 and 25 at least 20 days prior to the first day of each race meeting.

Upon compliance with the provisions of paragraphs (1), (2), and (3) of this subsection (h), the applicant shall be issued an organization license.

If any applicant fails to comply with this Section or fails to pay the organization license fees herein provided, no organization license shall be issued to such applicant.

(Source: P.A. 101-31, eff. 6-28-19.)

(230 ILCS 5/26) (from Ch. 8, par. 37-26)

Sec. 26. Wagering.

(a) Any licensee may conduct and supervise the pari-mutuel system of wagering, as defined in Section 3.12 of this Act, on horse races conducted by an Illinois organization licensee or conducted at a racetrack located in another state or country in accordance with subsection (g) of Section 26 of this Act. Subject to the prior consent of the Board, licensees may supplement any pari-mutuel pool in order to guarantee a minimum distribution. Such pari-mutuel method of wagering shall not, under any circumstances if conducted under the provisions of this Act, be held or construed to be unlawful, other statutes of this State to the contrary notwithstanding. Subject to rules for advance wagering promulgated by the Board, any licensee may accept wagers in advance of the day the race wagered upon occurs.

(b) Except for those gaming activities for which a license is obtained and authorized under the Illinois Lottery Law, the Charitable Games Act, the Raffles and Poker Runs Act, or the Illinois Gambling Act, no other method of betting, pool making, wagering or gambling shall be used or permitted by the licensee. Each licensee may retain, subject to the payment of all applicable taxes and purses, an amount not to exceed 17% of all money wagered under subsection (a) of this Section, except as may otherwise be permitted under this Act.

(b-5) An individual may place a wager under the pari-mutuel system from any licensed location authorized under this Act provided that wager is electronically recorded in the manner described in Section 3.12 of this Act. Any wager made electronically by an individual while physically on the premises of a licensee shall be deemed to have been made at the premises of that licensee.

(c) (Blank).

(c-5) The sum held by any licensee for payment of outstanding pari-mutuel tickets, if unclaimed prior to December 31 of the next year, shall be retained by the licensee for payment of such tickets until that date.

Within 10 days thereafter, the balance of such sum remaining unclaimed, less any uncashed supplements contributed by such licensee for the purpose of guaranteeing minimum distributions of any pari-mutuel pool, shall be evenly distributed to the purse account of the organization licensee and the organization licensee, except that the balance of the sum of all outstanding pari-mutuel tickets generated from simulcast wagering and inter-track wagering by an organization licensee located in a county with a population in excess of 230,000 and borders the Mississippi River or any licensee that derives its license from that organization licensee shall be evenly distributed to the purse account of the organization licensee and the organization licensee.

(d) A pari-mutuel ticket shall be honored until December 31 of the next calendar year, and the licensee shall pay the same and may charge the amount thereof against unpaid money similarly accumulated on account of pari-mutuel tickets not presented for payment.

(e) No licensee shall knowingly permit any minor, other than an employee of such licensee or an owner, trainer, jockey, driver, or employee thereof, to be admitted during a racing program unless accompanied by a parent or guardian, or any minor to be a patron of the pari-mutuel system of wagering conducted or supervised by it. The admission of any unaccompanied minor, other than an employee of the licensee or an owner, trainer, jockey, driver, or employee thereof at a race track is a Class C misdemeanor.

(f) Notwithstanding the other provisions of this Act, an organization licensee may contract with an entity in another state or country to permit any legal wagering entity in another state or country to accept wagers solely within such other state or country on races conducted by the organization licensee in this State. Beginning January 1, 2000, these wagers shall not be subject to State taxation. Until January 1, 2000, when the out-of-State entity conducts a pari-mutuel pool separate from the organization licensee, a privilege tax equal to 7 1/2% of all monies received by the organization licensee from entities in other states or countries pursuant to such contracts is imposed on the organization licensee, and such privilege tax shall be remitted to the Department of Revenue within 48 hours of receipt of the moneys from the simulcast. When the out-of-State entity conducts a combined pari-mutuel pool with the organization licensee, the tax shall be 10% of all monies received by the organization licensee with 25% of the receipts from this 10% tax to be distributed to the county in which the race was conducted.

An organization licensee may permit one or more of its races to be utilized for pari-mutuel wagering at one or more locations in other states and may transmit audio and visual signals of races the organization licensee conducts to one or more locations outside the State or country and may also permit pari-mutuel pools in other states or countries to be combined with its gross or net wagering pools or with wagering pools established by other states.

(g) A host track may accept interstate simulcast wagers on horse races conducted in other states or countries and shall control the number of signals and types of breeds of racing in its simulcast program, subject to the disapproval of the Board. The Board may prohibit a simulcast program only if it finds that the simulcast program is clearly adverse to the integrity of racing. The host track simulcast program shall include the signal of live racing of all organization licensees. All non-host licensees and advance deposit wagering licensees shall carry the signal of and accept wagers on live racing of all organization licensees. Advance deposit wagering licensees shall not be permitted to accept out-of-state wagers on any Illinois signal provided pursuant to this Section without the approval and consent of the organization licensee providing the signal. For one year after August 15, 2014 (the effective date of Public Act 98-968), non-host licensees may carry the host track simulcast program and shall accept wagers on all races included as part of the simulcast program of horse races conducted at race tracks located within North America upon which wagering is permitted. For a period of one year after August 15, 2014 (the effective date of Public Act 98-968), on horse races conducted at race tracks located outside of North America, non-host licensees may accept wagers on all races included as part of the simulcast program upon which wagering is permitted. Beginning August 15, 2015 (one year after the effective date of Public Act 98-968), non-host licensees may carry the host track simulcast program and shall accept wagers on all races included as part of the simulcast program upon which wagering is permitted. All organization licensees shall provide their live signal to all advance deposit wagering licensees for a simulcast commission fee not to exceed 6% of the advance deposit wagering licensee's Illinois handle on the organization licensee's signal without prior approval by the Board. The Board may adopt rules under which it may permit simulcast commission fees in excess of 6%. The Board shall adopt rules limiting the interstate commission fees charged to an advance deposit wagering licensee. The Board shall adopt rules regarding advance deposit wagering on interstate simulcast races that shall reflect, among other things, the General Assembly's desire to maximize revenues to the State, horsemen purses, and organization licensees. However, organization licensees providing live signals

pursuant to the requirements of this subsection (g) may petition the Board to withhold their live signals from an advance deposit wagering licensee if the organization licensee discovers and the Board finds reputable or credible information that the advance deposit wagering licensee is under investigation by another state or federal governmental agency, the advance deposit wagering licensee's license has been suspended in another state, or the advance deposit wagering licensee's license is in revocation proceedings in another state. The organization licensee's provision of their live signal to an advance deposit wagering licensee under this subsection (g) pertains to wagers placed from within Illinois. Advance deposit wagering licensees may place advance deposit wagering terminals at wagering facilities as a convenience to customers. The advance deposit wagering licensee shall not charge or collect any fee from purses for the placement of the advance deposit wagering terminals. The costs and expenses of the host track and non-host licensees associated with interstate simulcast wagering, other than the interstate commission fee, shall be borne by the host track and all non-host licensees incurring these costs. The interstate commission fee shall not exceed 5% of Illinois handle on the interstate simulcast race or races without prior approval of the Board. The Board shall promulgate rules under which it may permit interstate commission fees in excess of 5%. The interstate commission fee and other fees charged by the sending racetrack, including, but not limited to, satellite decoder fees, shall be uniformly applied to the host track and all non-host licensees.

Notwithstanding any other provision of this Act, an organization licensee, with the consent of the horsemen association representing the largest number of owners, trainers, jockeys, or standardbred drivers who race horses at that organization licensee's racing meeting, may maintain a system whereby advance deposit wagering may take place or an organization licensee, with the consent of the horsemen association representing the largest number of owners, trainers, jockeys, or standardbred drivers who race horses at that organization licensee's racing meeting, may contract with another person to carry out a system of advance deposit wagering. Such consent may not be unreasonably withheld. Only with respect to an appeal to the Board that consent for an organization licensee that maintains its own advance deposit wagering system is being unreasonably withheld, the Board shall issue a final order within 30 days after initiation of the appeal, and the organization licensee's advance deposit wagering system may remain operational during that 30-day period. The actions of any organization licensee who conducts advance deposit wagering or any person who has a contract with an organization licensee to conduct advance deposit wagering who conducts advance deposit wagering on or after January 1, 2013 and prior to June 7, 2013 (the effective date of Public Act 98-18) taken in reliance on the changes made to this subsection (g) by Public Act 98-18 are hereby validated, provided payment of all applicable pari-mutuel taxes are remitted to the Board. All advance deposit wagers placed from within Illinois must be placed through a Board-approved advance deposit wagering licensee; no other entity may accept an advance deposit wager from a person within Illinois. All advance deposit wagering is subject to any rules adopted by the Board. The Board may adopt rules necessary to regulate advance deposit wagering through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. The General Assembly finds that the adoption of rules to regulate advance deposit wagering is deemed an emergency and necessary for the public interest, safety, and welfare. An advance deposit wagering licensee may retain all moneys as agreed to by contract with an organization licensee. Any moneys retained by the organization licensee from advance deposit wagering, not including moneys retained by the advance deposit wagering licensee, shall be paid 50% to the organization licensee's purse account and 50% to the organization licensee. With the exception of any organization licensee that is owned by a publicly traded company that is incorporated in a state other than Illinois and advance deposit wagering licensees under contract with such organization licensees, organization licensees that maintain advance deposit wagering systems and advance deposit wagering licensees that contract with organization licensees shall provide sufficiently detailed monthly accountings to the horsemen association representing the largest number of owners, trainers, jockeys, or standardbred drivers who race horses at that organization licensee's racing meeting so that the horsemen association, as an interested party, can confirm the accuracy of the amounts paid to the purse account at the horsemen association's affiliated organization licensee from advance deposit wagering. If more than one breed races at the same race track facility, then the 50% of the moneys to be paid to an organization licensee's purse account shall be allocated among all organization licensees' purse accounts operating at that race track facility proportionately based on the actual number of host days that the Board grants to that breed at that race track facility in the current calendar year. To the extent any fees from advance deposit wagering conducted in Illinois for wagers in Illinois or other states have been placed in escrow or otherwise withheld from wagers pending a determination of the legality of advance deposit wagering, no action shall be brought to declare such wagers or the disbursement of any fees previously escrowed illegal.

(1) Between the hours of 6:30 a.m. and 6:30 p.m. an inter-track wagering licensee other than the host track may supplement the host track simulcast program with additional simulcast races or race programs, provided that between January 1 and the third Friday in February of any year, inclusive, if no live thoroughbred racing is occurring in Illinois during this period, only thoroughbred races may be used for supplemental interstate simulcast purposes. The Board shall withhold approval for a supplemental interstate simulcast only if it finds that the simulcast is clearly adverse to the integrity of racing. A supplemental interstate simulcast may be transmitted from an inter-track wagering licensee to its affiliated non-host licensees. The interstate commission fee for a supplemental interstate simulcast shall be paid by the non-host licensee and its affiliated non-host licensees receiving the simulcast.

(2) Between the hours of 6:30 p.m. and 6:30 a.m. an inter-track wagering licensee other than the host track may receive supplemental interstate simulcasts only with the consent of the host track, except when the Board finds that the simulcast is clearly adverse to the integrity of racing. Consent granted under this paragraph (2) to any inter-track wagering licensee shall be deemed consent to all non-host licensees. The interstate commission fee for the supplemental interstate simulcast shall be paid by all participating non-host licensees.

(3) Each licensee conducting interstate simulcast wagering may retain, subject to the payment of all applicable taxes and the purses, an amount not to exceed 17% of all money wagered. If any licensee conducts the pari-mutuel system wagering on races conducted at racetracks in another state or country, each such race or race program shall be considered a separate racing day for the purpose of determining the daily handle and computing the privilege tax of that daily handle as provided in subsection (a) of Section 27. Until January 1, 2000, from the sums permitted to be retained pursuant to this subsection, each inter-track wagering location licensee shall pay 1% of the pari-mutuel handle wagered on simulcast wagering to the Horse Racing Tax Allocation Fund, subject to the provisions of subparagraph (B) of paragraph (11) of subsection (h) of Section 26 of this Act.

(4) A licensee who receives an interstate simulcast may combine its gross or net pools with pools at the sending racetracks pursuant to rules established by the Board. All licensees combining their gross pools at a sending racetrack shall adopt the takeout percentages of the sending racetrack. A licensee may also establish a separate pool and takeout structure for wagering purposes on races conducted at race tracks outside of the State of Illinois. The licensee may permit pari-mutuel wagers placed in other states or countries to be combined with its gross or net wagering pools or other wagering pools.

(5) After the payment of the interstate commission fee (except for the interstate commission fee on a supplemental interstate simulcast, which shall be paid by the host track and by each non-host licensee through the host track) and all applicable State and local taxes, except as provided in subsection (g) of Section 27 of this Act, the remainder of moneys retained from simulcast wagering pursuant to this subsection (g), and Section 26.2 shall be divided as follows:

(A) For interstate simulcast wagers made at a host track, 50% to the host track and 50% to purses at the host track.

(B) For wagers placed on interstate simulcast races, supplemental simulcasts as defined in subparagraphs (1) and (2), and separately pooled races conducted outside of the State of Illinois made at a non-host licensee, 25% to the host track, 25% to the non-host licensee, and 50% to the purses at the host track.

(6) Notwithstanding any provision in this Act to the contrary, non-host licensees who derive their licenses from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River may receive supplemental interstate simulcast races at all times subject to Board approval, which shall be withheld only upon a finding that a supplemental interstate simulcast is clearly adverse to the integrity of racing.

(7) Effective January 1, 2017, notwithstanding any provision of this Act to the contrary, after payment of all applicable State and local taxes and interstate commission fees, non-host licensees who derive their licenses from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River shall retain 50% of the retention from interstate simulcast wagers and shall pay 50% to purses at the track from which the non-host licensee derives its license.

(7.1) Notwithstanding any other provision of this Act to the contrary, if no standardbred racing is conducted at a racetrack located in Madison County during any calendar year beginning on or after January 1, 2002, all moneys derived by that racetrack from simulcast wagering and inter-track

wagering that (1) are to be used for purses and (2) are generated between the hours of 6:30 p.m. and 6:30 a.m. during that calendar year shall be paid as follows:

(A) If the licensee that conducts horse racing at that racetrack requests from the Board at least as many racing dates as were conducted in calendar year 2000, 80% shall be paid to its thoroughbred purse account; and

(B) Twenty percent shall be deposited into the Illinois Colt Stakes Purse Distribution Fund and shall be paid to purses for standardbred races for Illinois conceived and foaled horses conducted at any county fairgrounds. The moneys deposited into the Fund pursuant to this subparagraph (B) shall be deposited within 2 weeks after the day they were generated, shall be in addition to and not in lieu of any other moneys paid to standardbred purses under this Act, and shall not be commingled with other moneys paid into that Fund. The moneys deposited pursuant to this subparagraph (B) shall be allocated as provided by the Department of Agriculture, with the advice and assistance of the Illinois Standardbred Breeders Fund Advisory Board.

(7.2) Notwithstanding any other provision of this Act to the contrary, if no thoroughbred racing is conducted at a racetrack located in Madison County during any calendar year beginning on or after January 1, 2002, all moneys derived by that racetrack from simulcast wagering and inter-track wagering that (1) are to be used for purses and (2) are generated between the hours of 6:30 a.m. and 6:30 p.m. during that calendar year shall be deposited as follows:

(A) If the licensee that conducts horse racing at that racetrack requests from the Board at least as many racing dates as were conducted in calendar year 2000, 80% shall be deposited into its standardbred purse account; and

(B) Twenty percent shall be deposited into the Illinois Colt Stakes Purse Distribution Fund. Moneys deposited into the Illinois Colt Stakes Purse Distribution Fund pursuant to this subparagraph (B) shall be paid to Illinois conceived and foaled thoroughbred breeders' programs and to thoroughbred purses for races conducted at any county fairgrounds for Illinois conceived and foaled horses at the discretion of the Department of Agriculture, with the advice and assistance of the Illinois Thoroughbred Breeders Fund Advisory Board. The moneys deposited into the Illinois Colt Stakes Purse Distribution Fund pursuant to this subparagraph (B) shall be deposited within 2 weeks after the day they were generated, shall be in addition to and not in lieu of any other moneys paid to thoroughbred purses under this Act, and shall not be commingled with other moneys deposited into that Fund.

(8) Notwithstanding any provision in this Act to the contrary, an organization licensee from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River and its affiliated non-host licensees shall not be entitled to share in any retention generated on racing, inter-track wagering, or simulcast wagering at any other Illinois wagering facility.

(8.1) Notwithstanding any provisions in this Act to the contrary, if 2 organization licensees are conducting standardbred race meetings concurrently between the hours of 6:30 p.m. and 6:30 a.m., after payment of all applicable State and local taxes and interstate commission fees, the remainder of the amount retained from simulcast wagering otherwise attributable to the host track and to host track purses shall be split daily between the 2 organization licensees and the purses at the tracks of the 2 organization licensees, respectively, based on each organization licensee's share of the total live handle for that day, provided that this provision shall not apply to any non-host licensee that derives its license from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River.

(9) (Blank).

(10) (Blank).

(11) (Blank).

(12) The Board shall have authority to compel all host tracks to receive the simulcast of any or all races conducted at the Springfield or DuQuoin State fairgrounds and include all such races as part of their simulcast programs.

(13) Notwithstanding any other provision of this Act, in the event that the total Illinois pari-mutuel handle on Illinois horse races at all wagering facilities in any calendar year is less than 75% of the total Illinois pari-mutuel handle on Illinois horse races at all such wagering facilities for calendar year 1994, then each wagering facility that has an annual total Illinois pari-mutuel handle on Illinois horse races that is less than 75% of the total Illinois pari-mutuel handle on Illinois horse races

at such wagering facility for calendar year 1994, shall be permitted to receive, from any amount otherwise payable to the purse account at the race track with which the wagering facility is affiliated in the succeeding calendar year, an amount equal to 2% of the differential in total Illinois pari-mutuel handle on Illinois horse races at the wagering facility between that calendar year in question and 1994 provided, however, that a wagering facility shall not be entitled to any such payment until the Board certifies in writing to the wagering facility the amount to which the wagering facility is entitled and a schedule for payment of the amount to the wagering facility, based on: (i) the racing dates awarded to the race track affiliated with the wagering facility during the succeeding year; (ii) the sums available or anticipated to be available in the purse account of the race track affiliated with the wagering facility for purses during the succeeding year; and (iii) the need to ensure reasonable purse levels during the payment period. The Board's certification shall be provided no later than January 31 of the succeeding year. In the event a wagering facility entitled to a payment under this paragraph (13) is affiliated with a race track that maintains purse accounts for both standardbred and thoroughbred racing, the amount to be paid to the wagering facility shall be divided between each purse account pro rata, based on the amount of Illinois handle on Illinois standardbred and thoroughbred racing respectively at the wagering facility during the previous calendar year. Annually, the General Assembly shall appropriate sufficient funds from the General Revenue Fund to the Department of Agriculture for payment into the thoroughbred and standardbred horse racing purse accounts at Illinois pari-mutuel tracks. The amount paid to each purse account shall be the amount certified by the Illinois Racing Board in January to be transferred from each account to each eligible racing facility in accordance with the provisions of this Section. Beginning in the calendar year in which an organization licensee that is eligible to receive payment under this paragraph (13) begins to receive funds from gaming pursuant to an organization gaming license issued under the Illinois Gambling Act, the amount of the payment due to all wagering facilities licensed under that organization licensee under this paragraph (13) shall be the amount certified by the Board in January of that year. An organization licensee and its related wagering facilities shall no longer be able to receive payments under this paragraph (13) beginning in the year subsequent to the first year in which the organization licensee begins to receive funds from gaming pursuant to an organization gaming license issued under the Illinois Gambling Act.

(h) The Board may approve and license the conduct of inter-track wagering and simulcast wagering by inter-track wagering licensees and inter-track wagering location licensees subject to the following terms and conditions:

(1) Any person licensed to conduct a race meeting (i) at a track where 60 or more days of racing were conducted during the immediately preceding calendar year or where over the 5 immediately preceding calendar years an average of 30 or more days of racing were conducted annually may be issued an inter-track wagering license; (ii) at a track located in a county that is bounded by the Mississippi River, which has a population of less than 150,000 according to the 1990 decennial census, and an average of at least 60 days of racing per year between 1985 and 1993 may be issued an inter-track wagering license; (iii) at a track awarded standardbred racing dates; or (iv) at a track located in Madison County that conducted at least 100 days of live racing during the immediately preceding calendar year may be issued an inter-track wagering license, unless a lesser schedule of live racing is the result of (A) weather, unsafe track conditions, or other acts of God; (B) an agreement between the organization licensee and the associations representing the largest number of owners, trainers, jockeys, or standardbred drivers who race horses at that organization licensee's racing meeting; or (C) a finding by the Board of extraordinary circumstances and that it was in the best interest of the public and the sport to conduct fewer than 100 days of live racing. Any such person having operating control of the racing facility may receive inter-track wagering location licenses. An eligible race track located in a county that has a population of more than 230,000 and that is bounded by the Mississippi River may establish up to 18 ~~9~~ inter-track wagering locations, an eligible race track located in Stickney Township in Cook County may establish up to 16 inter-track wagering locations, and an eligible race track located in Palatine Township in Cook County may establish up to 18 inter-track wagering locations. An eligible racetrack conducting standardbred racing may have up to 16 inter-track wagering locations. An application for said license shall be filed with the Board prior to such dates as may be fixed by the Board. With an application for an inter-track wagering location license there shall be delivered to the Board a certified check or bank draft payable to the order of the Board for an amount equal to $500. The application shall be on forms prescribed and furnished by the

Board. The application shall comply with all other rules, regulations and conditions imposed by the Board in connection therewith.

(2) The Board shall examine the applications with respect to their conformity with this Act and the rules and regulations imposed by the Board. If found to be in compliance with the Act and rules and regulations of the Board, the Board may then issue a license to conduct inter-track wagering and simulcast wagering to such applicant. All such applications shall be acted upon by the Board at a meeting to be held on such date as may be fixed by the Board.

(3) In granting licenses to conduct inter-track wagering and simulcast wagering, the Board shall give due consideration to the best interests of the public, of horse racing, and of maximizing revenue to the State.

(4) Prior to the issuance of a license to conduct inter-track wagering and simulcast wagering, the applicant shall file with the Board a bond payable to the State of Illinois in the sum of $50,000, executed by the applicant and a surety company or companies authorized to do business in this State, and conditioned upon (i) the payment by the licensee of all taxes due under Section 27 or 27.1 and any other monies due and payable under this Act, and (ii) distribution by the licensee, upon presentation of the winning ticket or tickets, of all sums payable to the patrons of pari-mutuel pools.

(5) Each license to conduct inter-track wagering and simulcast wagering shall specify the person to whom it is issued, the dates on which such wagering is permitted, and the track or location where the wagering is to be conducted.

(6) All wagering under such license is subject to this Act and to the rules and regulations from time to time prescribed by the Board, and every such license issued by the Board shall contain a recital to that effect.

(7) An inter-track wagering licensee or inter-track wagering location licensee may accept wagers at the track or location where it is licensed, or as otherwise provided under this Act.

(8) Inter-track wagering or simulcast wagering shall not be conducted at any track less than 4 miles from a track at which a racing meeting is in progress.

(8.1) Inter-track wagering location licensees who derive their licenses from a particular organization licensee shall conduct inter-track wagering and simulcast wagering only at locations that are within 160 miles of that race track where the particular organization licensee is licensed to conduct racing. However, inter-track wagering and simulcast wagering shall not be conducted by those licensees at any location within 5 miles of any race track at which a horse race meeting has been licensed in the current year, unless the person having operating control of such race track has given its written consent to such inter-track wagering location licensees, which consent must be filed with the Board at or prior to the time application is made. In the case of any inter-track wagering location licensee initially licensed after December 31, 2013, inter-track wagering and simulcast wagering shall not be conducted by those inter-track wagering location licensees that are located outside the City of Chicago at any location within 8 miles of any race track at which a horse race meeting has been licensed in the current year, unless the person having operating control of such race track has given its written consent to such inter-track wagering location licensees, which consent must be filed with the Board at or prior to the time application is made.

(8.2) Inter-track wagering or simulcast wagering shall not be conducted by an inter-track wagering location licensee at any location within 100 feet of an existing church, an existing elementary or secondary public school, or an existing elementary or secondary private school registered with or recognized by the State Board of Education. The distance of 100 feet shall be measured to the nearest part of any building used for worship services, education programs, or conducting inter-track wagering by an inter-track wagering location licensee, and not to property boundaries. However, inter-track wagering or simulcast wagering may be conducted at a site within 100 feet of a church or school if such church or school has been erected or established after the Board issues the original inter-track wagering location license at the site in question. Inter-track wagering location licensees may conduct inter-track wagering and simulcast wagering only in areas that are zoned for commercial or manufacturing purposes or in areas for which a special use has been approved by the local zoning authority. However, no license to conduct inter-track wagering and simulcast wagering shall be granted by the Board with respect to any inter-track wagering location within the jurisdiction of any local zoning authority which has, by ordinance or by resolution, prohibited the establishment of an inter-track wagering location within its jurisdiction. However, inter-track wagering and simulcast wagering may be conducted at a site if such ordinance or

resolution is enacted after the Board licenses the original inter-track wagering location licensee for the site in question.

(9) (Blank).

(10) An inter-track wagering licensee or an inter-track wagering location licensee may retain, subject to the payment of the privilege taxes and the purses, an amount not to exceed 17% of all money wagered. Each program of racing conducted by each inter-track wagering licensee or inter-track wagering location licensee shall be considered a separate racing day for the purpose of determining the daily handle and computing the privilege tax or pari-mutuel tax on such daily handle as provided in Section 27.

(10.1) Except as provided in subsection (g) of Section 27 of this Act, inter-track wagering location licensees shall pay 1% of the pari-mutuel handle at each location to the municipality in which such location is situated and 1% of the pari-mutuel handle at each location to the county in which such location is situated. In the event that an inter-track wagering location licensee is situated in an unincorporated area of a county, such licensee shall pay 2% of the pari-mutuel handle from such location to such county. Inter-track wagering location licensees must pay the handle percentage required under this paragraph to the municipality and county no later than the 20th of the month following the month such handle was generated.

(10.2) Notwithstanding any other provision of this Act, with respect to inter-track wagering at a race track located in a county that has a population of more than 230,000 and that is bounded by the Mississippi River ("the first race track"), or at a facility operated by an inter-track wagering licensee or inter-track wagering location licensee that derives its license from the organization licensee that operates the first race track, on races conducted at the first race track or on races conducted at another Illinois race track and simultaneously televised to the first race track or to a facility operated by an inter-track wagering licensee or inter-track wagering location licensee that derives its license from the organization licensee that operates the first race track, those moneys shall be allocated as follows:

(A) That portion of all moneys wagered on standardbred racing that is required under this Act to be paid to purses shall be paid to purses for standardbred races.

(B) That portion of all moneys wagered on thoroughbred racing that is required under this Act to be paid to purses shall be paid to purses for thoroughbred races.

(11) (A) After payment of the privilege or pari-mutuel tax, any other applicable taxes, and the costs and expenses in connection with the gathering, transmission, and dissemination of all data necessary to the conduct of inter-track wagering, the remainder of the monies retained under either Section 26 or Section 26.2 of this Act by the inter-track wagering licensee on inter-track wagering shall be allocated with 50% to be split between the 2 participating licensees and 50% to purses, except that an inter-track wagering licensee that derives its license from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River shall not divide any remaining retention with the Illinois organization licensee that provides the race or races, and an inter-track wagering licensee that accepts wagers on races conducted by an organization licensee that conducts a race meet in a county with a population in excess of 230,000 and that borders the Mississippi River shall not divide any remaining retention with that organization licensee.

(B) From the sums permitted to be retained pursuant to this Act each inter-track wagering location licensee shall pay (i) the privilege or pari-mutuel tax to the State; (ii) 4.75% of the pari-mutuel handle on inter-track wagering at such location on races as purses, except that an inter-track wagering location licensee that derives its license from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River shall retain all purse moneys for its own purse account consistent with distribution set forth in this subsection (h), and inter-track wagering location licensees that accept wagers on races conducted by an organization licensee located in a county with a population in excess of 230,000 and that borders the Mississippi River shall distribute all purse moneys to purses at the operating host track; (iii) until January 1, 2000, except as provided in subsection (g) of Section 27 of this Act, 1% of the pari-mutuel handle wagered on inter-track wagering and simulcast wagering at each inter-track wagering location licensee facility to the Horse Racing Tax Allocation Fund, provided that, to the extent the total amount collected and distributed to the Horse Racing Tax Allocation Fund under this subsection (h) during any calendar year exceeds the amount collected and distributed to the Horse Racing Tax Allocation Fund during calendar year 1994, that excess amount shall be redistributed (I) to all inter-track wagering location licensees, based on each licensee's pro rata share of the total handle from inter-track wagering and

simulcast wagering for all inter-track wagering location licensees during the calendar year in which this provision is applicable; then (II) the amounts redistributed to each inter-track wagering location licensee as described in subpart (I) shall be further redistributed as provided in subparagraph (B) of paragraph (5) of subsection (g) of this Section 26 provided first, that the shares of those amounts, which are to be redistributed to the host track or to purses at the host track under subparagraph (B) of paragraph (5) of subsection (g) of this Section 26 shall be redistributed based on each host track's pro rata share of the total inter-track wagering and simulcast wagering handle at all host tracks during the calendar year in question, and second, that any amounts redistributed as described in part (I) to an inter-track wagering location licensee that accepts wagers on races conducted by an organization licensee that conducts a race meet in a county with a population in excess of 230,000 and that borders the Mississippi River shall be further redistributed, effective January 1, 2017, as provided in paragraph (7) of subsection (g) of this Section 26, with the portion of that further redistribution allocated to purses at that organization licensee to be divided between standardbred purses and thoroughbred purses based on the amounts otherwise allocated to purses at that organization licensee during the calendar year in question; and (iv) 8% of the pari-mutuel handle on inter-track wagering wagered at such location to satisfy all costs and expenses of conducting its wagering. The remainder of the monies retained by the inter-track wagering location licensee shall be allocated 40% to the location licensee and 60% to the organization licensee which provides the Illinois races to the location, except that an inter-track wagering location licensee that derives its license from a track located in a county with a population in excess of 230,000 and that borders the Mississippi River shall not divide any remaining retention with the organization licensee that provides the race or races and an inter-track wagering location licensee that accepts wagers on races conducted by an organization licensee that conducts a race meet in a county with a population in excess of 230,000 and that borders the Mississippi River shall not divide any remaining retention with the organization licensee. Notwithstanding the provisions of clauses (ii) and (iv) of this paragraph, in the case of the additional inter-track wagering location licenses authorized under paragraph (1) of this subsection (h) by Public Act 87-110, those licensees shall pay the following amounts as purses: during the first 12 months the licensee is in operation, 5.25% of the pari-mutuel handle wagered at the location on races; during the second 12 months, 5.25%; during the third 12 months, 5.75%; during the fourth 12 months, 6.25%; and during the fifth 12 months and thereafter, 6.75%. The following amounts shall be retained by the licensee to satisfy all costs and expenses of conducting its wagering: during the first 12 months the licensee is in operation, 8.25% of the pari-mutuel handle wagered at the location; during the second 12 months, 8.25%; during the third 12 months, 7.75%; during the fourth 12 months, 7.25%; and during the fifth 12 months and thereafter, 6.75%. For additional inter-track wagering location licensees authorized under Public Act 89-16, purses for the first 12 months the licensee is in operation shall be 5.75% of the pari-mutuel wagered at the location, purses for the second 12 months the licensee is in operation shall be 6.25%, and purses thereafter shall be 6.75%. For additional inter-track location licensees authorized under Public Act 89-16, the licensee shall be allowed to retain to satisfy all costs and expenses: 7.75% of the pari-mutuel handle wagered at the location during its first 12 months of operation, 7.25% during its second 12 months of operation, and 6.75% thereafter.

(C) There is hereby created the Horse Racing Tax Allocation Fund which shall remain in existence until December 31, 1999. Moneys remaining in the Fund after December 31, 1999 shall be paid into the General Revenue Fund. Until January 1, 2000, all monies paid into the Horse Racing Tax Allocation Fund pursuant to this paragraph (11) by inter-track wagering location licensees located in park districts of 500,000 population or less, or in a municipality that is not included within any park district but is included within a conservation district and is the county seat of a county that (i) is contiguous to the state of Indiana and (ii) has a 1990 population of 88,257 according to the United States Bureau of the Census, and operating on May 1, 1994 shall be allocated by appropriation as follows:

Two-sevenths to the Department of Agriculture. Fifty percent of this two-sevenths shall be used to promote the Illinois horse racing and breeding industry, and shall be distributed by the Department of Agriculture upon the advice of a 9-member committee appointed by the Governor consisting of the following members: the Director of Agriculture, who shall serve as chairman; 2 representatives of organization licensees conducting thoroughbred race meetings in this State, recommended by those licensees; 2 representatives of organization licensees conducting standardbred race meetings in this State, recommended by those licensees; a

representative of the Illinois Thoroughbred Breeders and Owners Foundation, recommended by that Foundation; a representative of the Illinois Standardbred Owners and Breeders Association, recommended by that Association; a representative of the Horsemen's Benevolent and Protective Association or any successor organization thereto established in Illinois comprised of the largest number of owners and trainers, recommended by that Association or that successor organization; and a representative of the Illinois Harness Horsemen's Association, recommended by that Association. Committee members shall serve for terms of 2 years, commencing January 1 of each even-numbered year. If a representative of any of the above-named entities has not been recommended by January 1 of any even-numbered year, the Governor shall appoint a committee member to fill that position. Committee members shall receive no compensation for their services as members but shall be reimbursed for all actual and necessary expenses and disbursements incurred in the performance of their official duties. The remaining 50% of this two-sevenths shall be distributed to county fairs for premiums and rehabilitation as set forth in the Agricultural Fair Act;

Four-sevenths to park districts or municipalities that do not have a park district of 500,000 population or less for museum purposes (if an inter-track wagering location licensee is located in such a park district) or to conservation districts for museum purposes (if an inter-track wagering location licensee is located in a municipality that is not included within any park district but is included within a conservation district and is the county seat of a county that (i) is contiguous to the state of Indiana and (ii) has a 1990 population of 88,257 according to the United States Bureau of the Census, except that if the conservation district does not maintain a museum, the monies shall be allocated equally between the county and the municipality in which the inter-track wagering location licensee is located for general purposes) or to a municipal recreation board for park purposes (if an inter-track wagering location licensee is located in a municipality that is not included within any park district and park maintenance is the function of the municipal recreation board and the municipality has a 1990 population of 9,302 according to the United States Bureau of the Census); provided that the monies are distributed to each park district or conservation district or municipality that does not have a park district in an amount equal to four-sevenths of the amount collected by each inter-track wagering location licensee within the park district or conservation district or municipality for the Fund. Monies that were paid into the Horse Racing Tax Allocation Fund before August 9, 1991 (the effective date of Public Act 87-110) by an inter-track wagering location licensee located in a municipality that is not included within any park district but is included within a conservation district as provided in this paragraph shall, as soon as practicable after August 9, 1991 (the effective date of Public Act 87-110), be allocated and paid to that conservation district as provided in this paragraph. Any park district or municipality not maintaining a museum may deposit the monies in the corporate fund of the park district or municipality where the inter-track wagering location is located, to be used for general purposes; and

One-seventh to the Agricultural Premium Fund to be used for distribution to agricultural home economics extension councils in accordance with "An Act in relation to additional support and finances for the Agricultural and Home Economic Extension Councils in the several counties of this State and making an appropriation therefor", approved July 24, 1967.

Until January 1, 2000, all other monies paid into the Horse Racing Tax Allocation Fund pursuant to this paragraph (11) shall be allocated by appropriation as follows:

Two-sevenths to the Department of Agriculture. Fifty percent of this two-sevenths shall be used to promote the Illinois horse racing and breeding industry, and shall be distributed by the Department of Agriculture upon the advice of a 9-member committee appointed by the Governor consisting of the following members: the Director of Agriculture, who shall serve as chairman; 2 representatives of organization licensees conducting thoroughbred race meetings in this State, recommended by those licensees; 2 representatives of organization licensees conducting standardbred race meetings in this State, recommended by those licensees; a representative of the Illinois Thoroughbred Breeders and Owners Foundation, recommended by that Foundation; a representative of the Illinois Standardbred Owners and Breeders Association, recommended by that Association; a representative of the Horsemen's Benevolent and Protective Association or any successor organization thereto established in Illinois comprised of the largest number of owners and trainers, recommended by that Association or that successor

organization; and a representative of the Illinois Harness Horsemen's Association, recommended by that Association. Committee members shall serve for terms of 2 years, commencing January 1 of each even-numbered year. If a representative of any of the above-named entities has not been recommended by January 1 of any even-numbered year, the Governor shall appoint a committee member to fill that position. Committee members shall receive no compensation for their services as members but shall be reimbursed for all actual and necessary expenses and disbursements incurred in the performance of their official duties. The remaining 50% of this two-sevenths shall be distributed to county fairs for premiums and rehabilitation as set forth in the Agricultural Fair Act;

Four-sevenths to museums and aquariums located in park districts of over 500,000 population; provided that the monies are distributed in accordance with the previous year's distribution of the maintenance tax for such museums and aquariums as provided in Section 2 of the Park District Aquarium and Museum Act; and

One-seventh to the Agricultural Premium Fund to be used for distribution to agricultural home economics extension councils in accordance with "An Act in relation to additional support and finances for the Agricultural and Home Economic Extension Councils in the several counties of this State and making an appropriation therefor", approved July 24, 1967. This subparagraph (C) shall be inoperative and of no force and effect on and after January 1, 2000.

(D) Except as provided in paragraph (11) of this subsection (h), with respect to purse allocation from inter-track wagering, the monies so retained shall be divided as follows:

(i) If the inter-track wagering licensee, except an inter-track wagering licensee that derives its license from an organization licensee located in a county with a population in excess of 230,000 and bounded by the Mississippi River, is not conducting its own race meeting during the same dates, then the entire purse allocation shall be to purses at the track where the races wagered on are being conducted.

(ii) If the inter-track wagering licensee, except an inter-track wagering licensee that derives its license from an organization licensee located in a county with a population in excess of 230,000 and bounded by the Mississippi River, is also conducting its own race meeting during the same dates, then the purse allocation shall be as follows: 50% to purses at the track where the races wagered on are being conducted; 50% to purses at the track where the inter-track wagering licensee is accepting such wagers.

(iii) If the inter-track wagering is being conducted by an inter-track wagering location licensee, except an inter-track wagering location licensee that derives its license from an organization licensee located in a county with a population in excess of 230,000 and bounded by the Mississippi River, the entire purse allocation for Illinois races shall be to purses at the track where the race meeting being wagered on is being held.

(12) The Board shall have all powers necessary and proper to fully supervise and control the conduct of inter-track wagering and simulcast wagering by inter-track wagering licensees and inter-track wagering location licensees, including, but not limited to, the following:

(A) The Board is vested with power to promulgate reasonable rules and regulations for the purpose of administering the conduct of this wagering and to prescribe reasonable rules, regulations and conditions under which such wagering shall be held and conducted. Such rules and regulations are to provide for the prevention of practices detrimental to the public interest and for the best interests of said wagering and to impose penalties for violations thereof.

(B) The Board, and any person or persons to whom it delegates this power, is vested with the power to enter the facilities of any licensee to determine whether there has been compliance with the provisions of this Act and the rules and regulations relating to the conduct of such wagering.

(C) The Board, and any person or persons to whom it delegates this power, may eject or exclude from any licensee's facilities, any person whose conduct or reputation is such that his presence on such premises may, in the opinion of the Board, call into the question the honesty and integrity of, or interfere with the orderly conduct of such wagering; provided, however, that no person shall be excluded or ejected from such premises solely on the grounds of race, color, creed, national origin, ancestry, or sex.

(D) (Blank).

(E) The Board is vested with the power to appoint delegates to execute any of the powers granted to it under this Section for the purpose of administering this wagering and any rules and regulations promulgated in accordance with this Act.

(F) The Board shall name and appoint a State director of this wagering who shall be a representative of the Board and whose duty it shall be to supervise the conduct of inter-track wagering as may be provided for by the rules and regulations of the Board; such rules and regulation shall specify the method of appointment and the Director's powers, authority and duties.

(G) The Board is vested with the power to impose civil penalties of up to $5,000 against individuals and up to $10,000 against licensees for each violation of any provision of this Act relating to the conduct of this wagering, any rules adopted by the Board, any order of the Board or any other action which in the Board's discretion, is a detriment or impediment to such wagering.

(13) The Department of Agriculture may enter into agreements with licensees authorizing such licensees to conduct inter-track wagering on races to be held at the licensed race meetings conducted by the Department of Agriculture. Such agreement shall specify the races of the Department of Agriculture's licensed race meeting upon which the licensees will conduct wagering. In the event that a licensee conducts inter-track pari-mutuel wagering on races from the Illinois State Fair or DuQuoin State Fair which are in addition to the licensee's previously approved racing program, those races shall be considered a separate racing day for the purpose of determining the daily handle and computing the privilege or pari-mutuel tax on that daily handle as provided in Sections 27 and 27.1. Such agreements shall be approved by the Board before such wagering may be conducted. In determining whether to grant approval, the Board shall give due consideration to the best interests of the public and of horse racing. The provisions of paragraphs (1), (8), (8.1), and (8.2) of subsection (h) of this Section which are not specified in this paragraph (13) shall not apply to licensed race meetings conducted by the Department of Agriculture at the Illinois State Fair in Sangamon County or the DuQuoin State Fair in Perry County, or to any wagering conducted on those race meetings.

(14) An inter-track wagering location license authorized by the Board in 2016 that is owned and operated by a race track in Rock Island County shall be transferred to a commonly owned race track in Cook County on August 12, 2016 (the effective date of Public Act 99-757). The licensee shall retain its status in relation to purse distribution under paragraph (11) of this subsection (h) following the transfer to the new entity. The pari-mutuel tax credit under Section 32.1 shall not be applied toward any pari-mutuel tax obligation of the inter-track wagering location licensee of the license that is transferred under this paragraph (14).

(i) Notwithstanding the other provisions of this Act, the conduct of wagering at wagering facilities is authorized on all days, except as limited by subsection (b) of Section 19 of this Act.

(Source: P.A. 101-31, eff. 6-28-19; 101-52, eff. 7-12-19; 101-81, eff. 7-12-19; 101-109, eff. 7-19-19; 102-558, eff. 8-20-21; 102-813, eff. 5-13-22.)

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.

At the hour of 4:40 o'clock p.m., Senator Holmes, presiding.

At the hour of 4:45 o'clock p.m., Senator Aquino, presiding.

REPORT FROM COMMITTEE ON ASSIGNMENTS

Senator Cunningham, Vice-Chair of the Committee on Assignments, during its May 29, 2025 meeting, reported the following Legislative Measures have been assigned to the indicated Standing Committees of the Senate:

Executive: **House Bills Numbered 850 and 3247; Floor Amendment No. 2 to House Bill 2771; Floor Amendment No. 3 to House Bill 2785; Committee Amendment No. 3 to House Bill 3363; Motion to Concur in House Amendment No. 1 to Senate Bill 1994**.

Licensed Activities: **Motion to Concur in House Amendment No. 1 to Senate Bill 2431**

State Government: **Motion to Concur in House Amendment No. 1 to Senate Bill 314**

Senator Cunningham, Vice-Chair of the Committee on Assignments, during its May 29, 2025 meeting, reported that the following Legislative Measures have been approved for consideration:

Floor Amendment No. 3 to House Bill 1697
Floor Amendment No. 4 to House Bill 1697
Floor Amendment No. 2 to House Bill 2967
Floor Amendment No. 2 to House Bill 3019
Floor Amendment No. 4 to House Bill 3193

The foregoing floor amendments were placed on the Secretary's Desk.

Senator Cunningham, Vice-Chair of the Committee on Assignments, during its May 29, 2025 meeting, reported that the following Legislative Measure has been approved for consideration:

House Joint Resolution No. 13

The foregoing resolution was placed on the Senate Calendar.

LEGISLATIVE MEASURE FILED

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

Amendment No. 5 to House Bill 1697

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Johnson, **House Bill No. 22** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 33; NAYS 21; Present 1.

The following voted in the affirmative:

Aquino	Glowiak Hilton	Martwick	Ventura
Belt	Guzmán	Morrison	Villa
Castro	Halpin	Murphy	Villanueva
Cervantes	Harris, N.	Peters	Villivalam
Cunningham	Holmes	Porfirio	Walker
Edly-Allen	Hunter	Preston	Mr. President
Ellman	Johnson	Simmons	
Faraci	Jones, E.	Sims	
Feigenholtz	Koehler	Turner, D.	

The following voted in the negative:

Anderson	DeWitte	Lewis	Tracy
Arellano, L.	Fowler	McClure	Turner, S.
Balkema	Harriss, E.	Plummer	Wilcox
Bryant	Hastings	Rezin	
Chesney	Hills	Rose	
Curran	Joyce	Syverson	

The following voted present:

Collins

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 in the Senate Amendment adopted thereto.

Senator Fine asked and obtained unanimous consent for the Journal to reflect her intention to have voted in the affirmative on **House Bill No. 22**.

On motion of Senator Johnson, **House Bill No. 32** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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 in the Senate Amendment adopted thereto.

On motion of Senator S. Turner, **House Bill No. 1082** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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.

On motion of Senator Halpin, **House Bill No. 1576** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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 in the Senate Amendment adopted thereto.

On motion of Senator Peters, **House Bill No. 1302** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Mr. President
Curran	Holmes	Rezin	
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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 in the Senate Amendments adopted thereto.

On motion of Senator Belt, **House Bill No. 1616** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Ellman	Johnson	Rose
Aquino	Faraci	Jones, E.	Simmons
Arellano, L.	Feigenholtz	Joyce	Sims
Balkema	Fine	Koehler	Stadelman
Belt	Fowler	Lewis	Syverson
Bryant	Glowiak Hilton	Martwick	Turner, D.
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	Mr. President
Edly-Allen	Hunter	Rezin	

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.

On motion of Senator Bryant, **House Bill No. 2327** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 57; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Wilcox
Curran	Holmes	Rezin	Mr. President
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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.

HOUSE BILL RECALLED

On motion of Senator Koehler, **House Bill No. 2371** was recalled from the order of third reading to the order of second reading.

Senator Koehler offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 2371

AMENDMENT NO. 2. Amend House Bill 2371, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Patient Access to Pharmacy Protection Act.

Section 5. Findings. The General Assembly finds that:

(1) It is within the traditional authority of the State to regulate the acquisition and delivery of drugs to pharmacies and providers.

(2) The federal 340B statute is silent on distribution of 340B-acquired drugs to 340B covered entities and their contract pharmacy partners.

(3) The State's compelling interest in preserving and improving access to health care services requires it to ensure that 340B covered entities continue to be allowed to contract with pharmacies to receive 340B drugs and dispense them to the patients of 340B covered entities in accordance with federal law.

(4) Addressing accessibility of these life-saving medications is a matter of health, safety, and welfare for the people of the State of Illinois.

Section 10. Definitions. As used in this Act:

"340B contract pharmacy" means any pharmacy that is under contract with a 340B covered entity to dispense 340B drugs on behalf of the 340B covered entity and is either (i) located in Illinois and qualifies as a pharmacy under Section 3 of the Pharmacy Practice Act; or (ii) is located in a state, commonwealth, or territory of the United States, other than Illinois, and dispenses 340B drugs on behalf of the 340B covered entity.

"340B covered entity" means an entity in Illinois that qualifies as a covered entity under Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b(a)(4).

"340B drug" means a drug that has been subject to any offer for reduced prices by a manufacturer pursuant to 42 U.S.C. 256b and is purchased by a 340B covered entity.

"340B drug discount program" means the program established under Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b.

"340B grantee" means an entity in Illinois that qualifies as a covered entity under subparagraphs (A)–(K) of paragraph (4) of subsection (a) of Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b(a)(4)(A)-(K).

"Critical Access Hospital" has the meaning given to that term in paragraph (4) of subsection (b) of Section 5-5e of the Illinois Public Aid Code.

"Hospital" means a hospital licensed under the Hospital Licensing Act or University of Illinois Hospital Act.

"Manufacturer" or "Pharmaceutical Manufacturer" has the meaning given to the term "manufacturer" in the Wholesale Drug Distribution Licensing Act.

"Person" includes a natural person, partnership, association, corporation, or any other legal business entity. "Person" does not include any federal or State government entity or body.

"Safety-Net Hospital" has the meaning given to that term in Section 5-5e.1 of the Illinois Public Aid Code.

Section 15. Protection of patient access to pharmacy.

(a) No person, including a pharmaceutical manufacturer, may deny, restrict, prohibit, condition, or otherwise interfere with, either directly or indirectly, the acquisition of a 340B drug by, or delivery of a 340B drug to, a 340B covered entity or a 340B contract pharmacy authorized to receive 340B drugs on behalf of the 340B covered entity unless the receipt is prohibited by federal law.

(b) No person, including a pharmaceutical manufacturer, may impose any restriction on the ability of a 340B covered entity to contract with or designate a 340B contract pharmacy, including restrictions relating to the number, location, ownership, or type of 340B contract pharmacy.

(c) No person, including a pharmaceutical manufacturer, may require or compel a 340B covered entity or 340B contract pharmacy to:

(1) submit or otherwise provide ingredient cost or pricing data pertinent to 340B drugs unless required by State or federal law;

(2) institute requirements in any way relating to how a 340B covered entity manages its inventory of 340B drugs that are not required by a State or federal agency, including requirements relating to the frequency or scope of audits of inventory management systems of a 340B covered entity or a 340B contract pharmacy; or

(3) submit data or information that is not required by a State or federal law as a condition for a 340B covered entity, its 340B contract pharmacy, or a location otherwise authorized by a 340B covered entity to receive 340B drugs.

(d) Each individual transaction, as defined in 21 U.S.C. 360eee-24, of 340B drugs that is subject to a prohibited act in subsections (a) and (b) shall constitute a separate violation of this Act.

Section 20. Reporting. On or before August 1, 2026 and each August 1 thereafter, a 340B covered entity shall submit a report to the General Assembly pursuant to this Section. For the purposes of this Section, the following covered entities are exempt until January 1, 2029 and will report on or before August 1, 2029 and each August 1 thereafter: hospitals with fewer than 100 licensed beds, Critical Access

Hospitals, Safety-Net Hospitals, and 340B grantees. The report must include all of the following for the 340B covered entity's 340B program:

(1) the name of the 340B covered entity submitting the report;

(2) a copy of the 340B covered entity's annual 340B program recertification;

(3) whether a community benefits plan report is required under Section 20 of the Community Benefits Act and, if so, a copy of the 340B covered entity's community benefits plan report, including a description of the amount of charity care provided by the 340B covered entity;

(4) the aggregate acquisition cost for prescription drugs obtained under the 340B program and dispensed or administered to patients;

(5) the aggregate payment amount received for all drugs obtained under the 340B program and dispensed or administered to patients;

(6) the number of claims for prescription drugs received under the 340B program;

(7) the percentage of the 340B covered entity's claims that were for prescription drugs obtained under the 340B program;

(8) a description of any adverse 340B program audits within the preceding 12 months; and

(9) a description of the impact of the 340B program on the patients and the community served by the 340B covered entity.

Section 25. Medicaid study.

(a) By January 1, 2028, the Department of Healthcare and Family Services shall report to the General Assembly on the following for the total aggregated covered outpatient drug units dispensed or administered in this State for the prior calendar year in connection with the medical assistance program under the Illinois Public Aid Code, categorized by (i) fee-for-service and (ii) each managed care plan:

(1) the number of dispensed or administered covered outpatient drug units;

(2) the number of dispensed or administered covered outpatient drug units that were subject to a rebate under 42 U.S.C. 1396r-8; and

(3) a reasonable estimate of net costs or savings to the State's medical assistance program due to 340B covered entity purchases of covered outpatient drug units at 340B pricing.

(b) To the extent the Department of Healthcare and Family Services lacks information to provide a data element required under subsection (a), it shall provide a reasonable estimate based on all available information and an explanation of the information that it lacks.

Section 30. 340B prescription drug applicability. Each 340B covered entity shall dispense or administer 340B drugs only when in connection with an outpatient health care service received by the patient within the last 18 months.

Section 35. Preventing duplication of 340B discounts. Each 340B covered entity shall develop and maintain a policy that ensures it is not placing an order for a 340B drug to replenish a prior pharmacy dispense if any other 340B covered entity will place an order for a 340B drug to replenish the same prior pharmacy dispense. The policy shall also include a process to reimburse a manufacturer for any duplicate 340B discount the covered entity receives. The policy shall be filed annually with the General Assembly.

Section 40. Enforcement.

(a) The Attorney General is authorized to enforce this Act under its general authority under the Attorney General Act.

(b) Upon finding a violation of Section 15 of this Act, a court may order:

(1) temporary, preliminary, or permanent injunctive relief for any act, policy, or practice that violates this Act;

(2) money damages to be paid to the 340B covered entity as a result of the violation of this Act;

(3) the assessment of a civil penalty of up to $1,000 for each violation of Section 15; or

(4) any other relief.

Section 45. Preemption.

(a) Nothing in this Act shall be construed or applied to be less restrictive than federal law for a person regulated by this Act.

(b) Nothing in this Act shall be construed or applied in a manner that would conflict with:

(1) applicable federal law; or

(2) other laws of this State if the State law is compatible with applicable federal law.

(c) Limited distribution of a drug required under 21 U.S.C. 355-1 may not to be construed as a violation of this Act.

Section 97. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application. Each paragraph defining "340B contract pharmacy" in Section 10 is severable.

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 bill, as amended, was ordered to a third reading.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Koehler, **House Bill No. 2371** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Ellman	Jones, E.	Sims
Aquino	Faraci	Joyce	Stadelman
Arellano, L.	Feigenholtz	Koehler	Syverson
Balkema	Fine	Lewis	Tracy
Belt	Fowler	Martwick	Turner, D.
Bryant	Glowiak Hilton	McClure	Turner, S.
Castro	Guzmán	Murphy	Ventura
Cervantes	Halpin	Peters	Villa
Chesney	Harris, N.	Plummer	Villanueva
Collins	Harriss, E.	Porfirio	Villivalam
Cunningham	Hastings	Preston	Walker
Curran	Hills	Rezin	Wilcox
DeWitte	Holmes	Rose	Mr. President
Edly-Allen	Hunter	Simmons	

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 in the Senate Amendments adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Fine, **House Bill No. 2387** was recalled from the order of third reading to the order of second reading.

Senator Fine offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 2387

AMENDMENT NO. 2 . Amend House Bill 2387, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Mental Health and Developmental Disabilities Code is amended by changing Sections 3-100 and 3-812 as follows:

(405 ILCS 5/3-100) (from Ch. 91 1/2, par. 3-100)

Sec. 3-100. Jurisdiction over involuntary admissions.

(a) The circuit court has jurisdiction under this Chapter over persons not charged with a felony who are subject to involuntary admission.

(b) The circuit court has jurisdiction over all persons who are subject to involuntary admission on an outpatient basis under Article VII-A of this Chapter. This subsection (b) is inoperative on and after January 1, 2030.

(c) Inmates of penal institutions shall not be considered as charged with a felony within the meaning of this Chapter. Court proceedings under Article VIII of this Chapter may be instituted as to any such inmate at any time within 90 days prior to discharge of such inmate by expiration of sentence or otherwise, and if such inmate is found to be subject to involuntary admission, the order of the court ordering hospitalization or other disposition shall become effective at the time of discharge of the inmate from penal custody.

(d) The circuit court has jurisdiction over all persons alleged to be in need of treatment under Section 2-107.1 of this Code, whether or not they are charged with a felony.

(Source: P.A. 99-179, eff. 7-29-15.)

(405 ILCS 5/3-812) (from Ch. 91 1/2, par. 3-812)

Sec. 3-812. Court ordered admission on an outpatient basis; modification; revocation.

(a) If a respondent is found subject to involuntary admission on an outpatient basis, the court may issue an order: (i) placing the respondent in the care and custody of a relative or other person willing and able to properly care for him or her; or (ii) committing the respondent to alternative treatment at a community mental health provider.

(b) An order placing the respondent in the care and custody of a relative or other person shall specify the powers and duties of the custodian. Unless the respondent is charged with a felony, an ~~An~~ order of care and custody entered pursuant to this Section may grant the custodian the authority to consent to the admission of ~~admit~~ a respondent to a hospital if the respondent fails to comply with the conditions of the order. If necessary in order to obtain the hospitalization of the respondent, the custodian may apply to the court for an order authorizing an officer of the peace to take the respondent into custody and transport the respondent to a mental health facility. The provisions of Section 3-605 shall govern the transportation of the respondent to a mental health facility, except to the extent that those provisions are inconsistent with this Section. No person admitted to a hospital pursuant to this subsection shall be detained for longer than 24 hours, excluding Saturdays, Sundays, and holidays, unless, within that period, a petition for involuntary admission on an inpatient basis and a certificate supporting such petition have been filed as provided in Section 3-611.

(c) Alternative treatment shall not be ordered unless the program being considered is capable of providing adequate and humane treatment in the least restrictive setting which is appropriate to the respondent's condition. The court shall have continuing authority to modify an order for alternative treatment if the recipient fails to comply with the order or is otherwise found unsuitable for alternative treatment. Prior to modifying such an order, the court shall receive a report from the facility director of the program specifying why the alternative treatment is unsuitable. The recipient shall be notified and given an opportunity to respond when modification of the order for alternative treatment is considered. If the court determines that the respondent has violated the order for alternative treatment in the community or that alternative treatment in the community will no longer provide adequate assurances for the safety of the respondent or others, the court may revoke the order for alternative treatment in the community and may order a peace officer to take the recipient into custody and transport him to an inpatient mental health facility. The provisions of Section 3-605 shall govern the transportation of the respondent to a mental health facility, except to the extent that those provisions are inconsistent with this Section. No person admitted to a hospital pursuant to this subsection shall be detained for longer than 24 hours, excluding Saturdays, Sundays, and holidays, unless, within that period, a petition for involuntary admission on an inpatient basis and a certificate supporting such petition have been filed as provided in Section 3-611.

(d) Noncompliance with an order placing the respondent in the care and custody of a relative or other person willing and able to properly care for him or her or committing the respondent to alternative treatment at a community mental health provider shall not be a basis for a finding of contempt.
(Source: P.A. 98-221, eff. 1-1-14.)

Section 10. The Clerks of Courts Act is amended by changing Section 27.1c as follows:
(705 ILCS 105/27.1c)
Sec. 27.1c. Assessment report.
(a) Not later than March 1, 2022, and March 1 of every year thereafter, the clerk of the circuit court shall submit to the Administrative Office of the Illinois Courts an annual report for the period January 1 through December 31 of the previous year. The report shall contain, with respect to each of the 4 categories of civil cases established by the Supreme Court pursuant to Section 27.1b of this Act:

(1) the total number of cases that were filed;

(2) the amount of filing fees that were collected pursuant to subsection (a) of Section 27.1b;

(3) the amount of appearance fees that were collected pursuant to subsection (b) of Section 27.1b;

(4) the amount of fees collected pursuant to subsection (b-5) of Section 27.1b;

(5) the amount of filing fees collected for counterclaims or third party complaints pursuant to subsection (c) of Section 27.1b;

(6) the nature and amount of any fees collected pursuant to subsection (y) of Section 27.1b; and

(7) the number of cases for which, pursuant to Section 5-105 of the Code of Civil Procedure, there were waivers of fees, costs, and charges of 25%, 50%, 75%, or 100%, respectively, and the associated amount of fees, costs, and charges that were waived.

(b) The Administrative Office of the Illinois Courts shall publish the reports submitted under this Section on its website.
(c) (Blank).
(c-5) Not later than March 1, 2026, and March 1 of every year thereafter, the clerk of the circuit court shall submit to the Administrative Office of the Illinois Courts a report for the previous calendar year containing the total number of petitions filed asserting that a person is subject to involuntary admission on an outpatient basis pursuant to Section 3-751 of the Mental Health and Developmental Disabilities Code. This subsection (c-5) is inoperative on and after January 1, 2030.
(Source: P.A. 101-645, eff. 6-26-20; 102-145, eff. 7-23-21.)".

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.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Fine, **House Bill No. 2387** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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	Feigenholtz	Koehler	Syverson
Aquino	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva

Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Wilcox
Curran	Holmes	Rezin	Mr. President
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	Sims	
Faraci	Joyce	Stadelman	

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 in the Senate Amendments adopted thereto.

Senator Arellano Jr. asked and obtained unanimous consent for the Journal to reflect his intention to have voted in the negative on **House Bill No. 2387**.

On motion of Senator Johnson, **House Bill No. 2425** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 36; NAYS 18; Present 1.

The following voted in the affirmative:

Aquino	Fine	Martwick	Ventura
Belt	Guzmán	Morrison	Villa
Castro	Halpin	Murphy	Villanueva
Cervantes	Harris, N.	Peters	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Holmes	Preston	Mr. President
Edly-Allen	Hunter	Simmons	
Ellman	Johnson	Sims	
Faraci	Jones, E.	Stadelman	
Feigenholtz	Koehler	Turner, D.	

The following voted in the negative:

Anderson	Curran	McClure	Tracy
Arellano, L.	DeWitte	Plummer	Turner, S.
Balkema	Fowler	Rezin	Wilcox
Bryant	Harriss, E.	Rose	
Chesney	Hills	Syverson	

The following voted present:

Lewis

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.

On motion of Senator Morrison, **House Bill No. 2516** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 45; NAYS 9.

The following voted in the affirmative:

Aquino	Feigenholtz	Jones, E.	Sims
Belt	Fine	Joyce	Stadelman
Bryant	Fowler	Koehler	Turner, D.
Castro	Glowiak Hilton	Lewis	Ventura
Cervantes	Guzmán	Martwick	Villa
Collins	Halpin	Morrison	Villanueva
Cunningham	Harris, N.	Murphy	Villivalam
Curran	Hastings	Peters	Walker
DeWitte	Hills	Porfirio	Mr. President
Edly-Allen	Holmes	Preston	
Ellman	Hunter	Rezin	
Faraci	Johnson	Simmons	

The following voted in the negative:

Arellano, L.	Harriss, E.	Syverson
Balkema	Plummer	Tracy
Chesney	Rose	Turner, S.

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 in the Senate Amendment adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Villanueva, **House Bill No. 2772** was recalled from the order of third reading to the order of second reading.

Senator Villanueva offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 2772

AMENDMENT NO. 2 . Amend House Bill 2772, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 1, on page 5, line 14, after "person", by inserting "employed by or acting on behalf of the Authority".

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.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Villanueva, **House Bill No. 2772** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 57; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Wilcox
Curran	Holmes	Rezin	Mr. President
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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 in the Senate Amendments adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Castro, **House Bill No. 2967** was recalled from the order of third reading to the order of second reading.

Senator Castro offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 2967

AMENDMENT NO. 2 . Amend House Bill 2967, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Dual Credit Quality Act is amended by changing Sections 5, 10, 15, 16, 17, 20, and 25 and by adding Sections 16.10, 19.5, 22, 45, and 50 as follows:

(110 ILCS 27/5)

Sec. 5. Definitions. In this Act:

"Dual credit course" means a college course taken by a high school student for credit at both the college and high school level.

"Postsecondary institution" ~~"Institution"~~ means an "institution of higher learning" as defined in the Higher Education Student Assistance Act.

(Source: P.A. 96-194, eff. 1-1-10.)

(110 ILCS 27/10)

Sec. 10. Purpose. The purpose of this Act is to accomplish all of the following:

(1) To reduce college costs.

(2) To speed time to degree completion.

(3) To improve the curriculum for high school students and the alignment of the curriculum with college and workplace expectations.

(4) To facilitate the transition between high school and college.

(5) To enhance communication and collaboration between high schools and colleges, which leads to the establishment of strong local partnerships that seek to expand opportunities for students.

(6) To offer opportunities for improving degree attainment for underserved student populations and provide meaningful educational opportunities that support student success and ensure dual credit is used as a strategic tool for closing opportunity gaps by increasing postsecondary completion.

(Source: P.A. 96-194, eff. 1-1-10.)

(110 ILCS 27/15)

Sec. 15. Student academic standing. Postsecondary institutions ~~Institutions~~ may adopt policies to protect the academic standing of students who are not successful in dual credit courses, including, but not limited to, options for (i) late withdrawal from a course, or (ii) taking the course on a pass-fail basis, or both. All institutional policies relating to the academic standing of students enrolled in dual credit courses or the transfer of credit for dual credit courses must be made publicly available by the postsecondary institution and provided to each student enrolled in dual credit courses offered by that postsecondary institution.

(Source: P.A. 100-1049, eff. 1-1-19.)

(110 ILCS 27/16)

Sec. 16. High school and community college partnership agreements; dual credit.

(a) A community college district shall, upon the written request of a school district within the jurisdiction of the community college district, enter into a partnership agreement with the school district to offer dual credit coursework.

The school district and community college district must designate a liaison and begin negotiations to reach a partnership agreement no later than 60 calendar days after the initial request.

A school district may offer any course identified in the Illinois Articulation Initiative General Education Core Curriculum package under the Illinois Articulation Initiative Act as a dual credit course on the campus of a high school of the school district and may use a high school instructor who has met the academic credential requirements under this Act to teach the dual credit course.

(b) The partnership agreement shall include all of the following:

(1) The establishment of the school district's and the community college district's respective roles and responsibilities in providing the program and ensuring the quality and instructional rigor of the program. This must include an assurance that the community college district has appropriate academic control of the curriculum, consistent with any State or federal law and as required or negotiated with the Higher Learning Commission or other applicable accrediting agency.

(2) The dual credit courses that the school district will offer its students and whether those courses will be offered on the high school or community college campus or through an online (hybrid or virtual) platform ~~established by the Illinois Community College Board~~.

(3) The establishment of academic criteria for granting eligibility for high school students to enroll in dual credit coursework. The academic criteria shall be evidence-based and shall include multiple appropriate measures to determine whether a student is prepared for any dual credit coursework in which the student enrolls.

(4) The establishment of any limitations that the school district or community college district may put on course offerings due to availability of instructors, the availability of students for specific course offerings, or local board policy.

(5) The requirement that the dual credit instructor meet the academic credential requirements to teach a dual credit course, consistent with paragraphs (1), (2), (2.5), and (3) of Section 20 of this Act, but shall not be required to exceed those minimum credentials.

(6) The collaborative process and criteria by which the school district shall identify and recommend and the community college district shall review and approve high school instructors of dual credit courses taught on the campus of a high school. This provision shall require that the school district be responsible for hiring and compensating the instructor.

(7) The requirement that a community college district take the appropriate steps to ensure that dual credit courses are equivalent to those courses offered at the community college in quality and rigor to qualify for college credit. The dual credit programs shall encompass the following characteristics:

(A) Student learning outcomes expected for dual credit courses in General Education Core Curriculum courses and the professional and career and technical disciplines shall be the same as the student learning outcomes expected for the same courses taught on the postsecondary campus.

(B) Course content, course delivery, and course rigor shall be evaluated by the community college chief academic officer or his or her designee, in consultation with the school district's superintendent or his or her designee. The evaluation shall be conducted in a manner that is consistent with the community college district's review and evaluation policy and procedures for on-campus adjunct faculty, including visits to the secondary class. This

evaluation shall be limited to the course and the ability of the instructor to deliver quality, rigorous college credit coursework. This evaluation shall not impact the instructor's performance evaluation under Article 24A of the School Code. This evaluation shall be completed within the same school year that the course is taught.

(C) The academic supports and, if applicable, guidance that will be provided to students participating in the program by the high school and the community college district.

(8) Identify all fees and costs to be assessed by the community college district for dual credit courses. This provision shall require that any fees and costs assessed for dual credit courses shall be reasonable and promote student access to those courses, and may take into account regional considerations and differences.

(8.5) The collaborative process and criteria by which a school district and a community college district shall work to ensure that individual students with disabilities have access to dual credit courses, provided that those students are able to meet the criteria for entry into a dual credit course. Through this process and criteria, the student shall have access to the supplementary aids and accommodations included in the student's individualized education program under Article 14 of the School Code or Section 504 plan under the federal Rehabilitation Act of 1973 while the student is accessing a dual credit course on a high school campus, in accordance with established practices at the high school for providing these services. A student who accesses a dual credit course on a community college campus shall have access to supplementary aids and accommodations provided in the partnership agreement, including access to the community college's disability services. A school district and community college district shall work together to provide seamless communication about the student's eligibility for disability services and dual credit course progress.

(9) The community college district shall establish a mechanism for evaluating and documenting on a regular basis the performance of students who complete dual credit courses, consistent with paragraph (9) of Section 20 and Section 30 of this Act, and for sharing that data in a meaningful and timely manner with the school district. This evaluation shall be limited to the course and the coursework. This evaluation shall not impact the instructor's performance evaluation under Article 24A of the School Code.

(10) The expectations for maintaining the rigor of dual credit courses that are taught at the high school and including students not deemed ready for college-level coursework according to the standards of the community college.

(11) A requirement that the school district and community college annually assess disaggregated data pertaining to dual credit course enrollments, completions, and subsequent postsecondary enrollment and performance to the extent feasible. If applicable, this assessment shall include an analysis of dual credit courses with credit sections for dual credit and for high school credit only pursuant to subsection (a) of Section 16.5 that reviews student characteristics by credit section in relation to gender, race and ethnicity, and low-income status.

~~If, within 180 calendar days of the school district's initial request to enter into a partnership agreement with the community college district, the school district and the community college district do not reach agreement on the partnership agreement, then the school district and community college district shall jointly implement the provisions of the Model Partnership Agreement established under Section 19 of this Act for which local agreement could not be reached. A community college district may combine its negotiations with multiple school districts to establish one multi-district partnership agreement or may negotiate individual partnership agreements at its discretion.~~

(Source: P.A. 102-516, eff. 8-20-21; 102-1077, eff. 1-1-23.)

(110 ILCS 27/16.10 new)

Sec. 16.10. Partnership agreement negotiations with liaison. Prior to offering dual credit coursework with any postsecondary institution other than a community college, a school district shall first negotiate with the designated liaison of the school district's local community college district to seek a partnership agreement with the community college district as provided in Section 16. After mutually agreeing that a partnership with the community college district is not feasible, the school district may enter into a partnership agreement with an alternative postsecondary institution that addresses each item listed in subsection (b) of Section 16.

(110 ILCS 27/17)

Sec. 17. Out-of-state dual credit contracts. On or after the effective date of this amendatory Act of the 100th General Assembly, a school district may not enter into a new contract with an out-of-state

postsecondary institution to provide a dual credit course without first offering the community college district in the district in which the school district is located the opportunity to provide the course. Prior to entering into a contract with an out-of-state postsecondary institution, the school district shall notify the Illinois Community College Board ~~Board of Higher Education~~ of its intent to enter into an agreement with an out-of-state postsecondary institution. The Illinois Community College Board ~~Board of Higher Education~~ shall have 30 days to provide the school district with a list of in-state postsecondary institutions that can provide the school district an equivalent dual credit opportunity. The school district may not enter into a contract with an out-of-state postsecondary institution on or after the effective date of this amendatory Act of the 104th General Assembly until the school district has demonstrated to the Illinois Community College Board that the school district has taken appropriate steps to consider the listing of in-state postsecondary institutions and provides a rationale as to why the course can be provided only by an out-of-state postsecondary institution; however, this limitation does not apply to a contract that was entered into prior to the effective date of this amendatory Act of the 104th General Assembly. In deciding which dual credit courses to offer, a school district reserves the right to evaluate any dual credit course offered by any postsecondary institution for quality, rigor, and alignment with the school district's students' needs.

Agreements to provide dual credit courses between a school district and an out-of-state postsecondary institution in existence on the effective date of this amendatory Act of the 100th General Assembly shall remain in effect and shall not be impacted by this Section.

(Source: P.A. 100-1049, eff. 1-1-19.)

(110 ILCS 27/19.5 new)

Sec. 19.5. Dual Credit Committee.

(a) Because postsecondary institutions and school districts are equally committed to the success of all students involved in dual credit and to ensure the equity and quality of the student experience that leads to college completion and increased economic mobility, a standing Dual Credit Committee involving collaboration between the Illinois Community College Board and the State Board of Education is created and shall consist of: the State Superintendent of Education or the Superintendent's designee; 10 members appointed by the State Superintendent, including one representative from a statewide professional teachers' organization and one representative from a different statewide professional teachers' organization; the Executive Director of the Illinois Community College Board or the Executive Director's designee; and 10 members appointed by the Executive Director of the Illinois Community College Board, including one member who is a community college faculty member who is a representative of a statewide professional teachers' organization and one member who is a community college faculty member who is a representative from a different statewide professional teachers' organization. The Executive Director of the Board of Higher Education or the Executive Director's designee shall serve as an ex-officio member.

(b) The Illinois Community College Board shall provide administrative support to the Committee.

(c) The Committee shall meet within 60 days after the effective date of this amendatory Act of the 104th General Assembly and subsequently shall meet at least annually to focus on approving accessibility, quality, and alignment of dual credit programs to meet the needs of students. The Committee may consider and develop updates to the Model Partnership Agreement and associated exhibits.

(110 ILCS 27/20)

Sec. 20. Standards. All postsecondary institutions offering dual credit courses shall meet the following standards:

(1) High school instructors teaching credit-bearing college-level courses for dual credit must meet any of the academic credential requirements set forth in this paragraph or paragraph (2), (2.5), or (3) of this Section and need not meet higher certification requirements or those set out in Article 21B of the School Code:

(A) Approved instructors of dual credit courses shall meet any of the faculty credential standards allowed by the Higher Learning Commission to determine minimally qualified faculty. At the request of an instructor, an instructor who meets these credential standards shall be provided by the State Board of Education with a Dual Credit Endorsement, to be placed on the professional educator license, as established by the State Board of Education and as authorized under Article 21B of the School Code and promulgated through administrative rule in cooperation with the Illinois Community College Board and the Board of Higher Education. The academic credentials required to be a fully qualified instructor shall include either (i) a master's degree in the discipline to be taught or (ii) a master's degree in any other discipline and a minimum of, but not more than, 18 graduate hours in the discipline to be taught.

(B) An instructor who does not meet the faculty credential standards allowed by the Higher Learning Commission to determine minimally qualified faculty may teach dual credit courses if the instructor has a professional development plan, approved by the postsecondary institution and shared with the State Board of Education ~~no later than January 1, 2025~~, to raise his or her credentials to be in line with the credentials under subparagraph (A) of this paragraph (1). The postsecondary institution shall have 30 days to review the plan and approve an instructor professional development plan that is in line with the credentials set forth in paragraph (2) or (2.5) of this Section. The postsecondary institution shall not unreasonably withhold approval of a professional development plan. These approvals shall be good for as long as satisfactory progress toward the completion of the credential is demonstrated, but in no event shall a professional development plan be in effect for more than 3 years from the date of its approval ~~or after January 1, 2028, whichever is sooner~~. A high school instructor whose professional development plan is not approved by the postsecondary institution may appeal to the Illinois Community College Board or the Board of Higher Education, as appropriate.

(C) The Illinois Community College Board and Board of Higher Education shall report yearly on their Internet websites the following:

(i) the number of teachers presently enrolled in an approved professional development plan under this Section;

(ii) the number of instructors who successfully completed an approved professional development plan;

(iii) the number of instructors who did not successfully complete an approved professional development plan after 3 years;

(iv) a breakdown of the information in subdivisions (i), (ii), and (iii) of this subparagraph (C) by subject area; and

(v) a summary, by community college district, of professional development plans that are in progress, that were successfully completed, or that have expired.

The State Board of Education shall provide the Illinois Community College Board and Board of Higher Education with any information necessary to complete the reporting required under this subparagraph (C).

(2) For a high school instructor entering into a professional development plan prior to January 1, 2023, the high school instructor shall qualify for a professional development plan if the instructor:

(A) has a master's degree in any discipline and has earned 9 graduate hours in a discipline in which he or she is currently teaching or expects to teach; or

(B) has a bachelor's degree with a minimum of 18 graduate hours in a discipline that he or she is currently teaching or expects to teach and is enrolled in a discipline-specific master's degree program; and

(C) agrees to demonstrate his or her progress toward completion to the supervising postsecondary institution, as outlined in the professional development plan.

(2.5) For a high school instructor entering into a professional development plan on or after January 1, 2023, the high school instructor shall qualify for a professional development plan if the instructor:

(A) has a master's degree in any discipline, has earned 9 graduate hours in a discipline in which he or she currently teaches or expects to teach, and agrees to demonstrate his or her progress toward completion to the supervising postsecondary institution, as outlined in the professional development plan; or

(B) is a fully licensed instructor in career and technical education who is halfway toward meeting the postsecondary institution's requirements for faculty in the discipline to be taught and agrees to demonstrate his or her progress toward completion to the supervising postsecondary institution, as outlined in the professional development plan.

(3) An instructor in career and technical education courses must possess the credentials and demonstrated teaching competencies appropriate to the field of instruction.

(4) Course content must be equivalent to credit-bearing college-level courses offered at the community college.

(5) Learning outcomes must be the same as credit-bearing college-level courses and be appropriately measured.

(6) A high school instructor is expected to participate in any orientation developed by the postsecondary institution for dual credit instructors in course curriculum, assessment methods, and administrative requirements.

(7) Dual credit instructors must be given the opportunity to participate in all activities available to other adjunct faculty, including professional development, seminars, site visits, and internal communication, provided that such opportunities do not interfere with an instructor's regular teaching duties.

(8) Every dual credit course must be reviewed annually by faculty through the appropriate department to ensure consistency with campus courses.

(9) Dual credit students must be assessed using methods consistent with students in traditional credit-bearing college courses.

(10) Within 15 days after entering into or renewing a partnership agreement, the postsecondary institution shall notify its faculty of the agreement, including access to copies of the agreement if requested.

(Source: P.A. 102-558, eff. 8-20-21; 102-1077, eff. 1-1-23; 103-154, eff. 6-30-23.)

(110 ILCS 27/22 new)

Sec. 22. Notification of disapproval or withdrawal; appeal. A community college district with an established partnership agreement with a school district has 30 calendar days from the initial course request to notify the school district of the community college district's disapproval of the course request, instructor, or course documentation or the community college district's withdrawal of course or instructor approval. Thereafter, the school district may appeal the disapproval or withdrawal to the Executive Director of the Illinois Community College Board within 14 calendar days after the notice is received. The Executive Director of the Illinois Community College Board shall render a decision within 45 calendar days after the appeal is filed and provide notice of the Executive Director's decision to the community college district and school district. The decision of the Executive Director may be appealed to the Illinois Community College Board by either the community college district or the school district within 30 calendar days after the decision by submitting a written request for reconsideration of the decision to the Illinois Community College Board. If no appeal is received within 30 calendar days, the Executive Director's decision shall be final and binding. The community college district and school district may make both oral and written presentations to the Illinois Community College Board at the time the decision is reconsidered. The Illinois Community College Board's decision shall be final and binding.

(1) If the Illinois Community College Board finds in favor of the school district with respect to the course, instructor, or course documentation but the community college district elects not to offer the course or approve the instructor or course documentation, the school district may pursue an alternative postsecondary institution to provide that course and must notify the community college district within 14 calendar days after the Illinois Community College Board's decision with the school district's intent to do so, along with the reason for seeking an alternative postsecondary institution.

(2) If the Illinois Community College Board finds in favor of the community college district's decision to disapprove the school district's course request, instructor, or course documentation or the community college district's withdrawal of course or instructor approval, the school district may not approach an alternative postsecondary institution, including another community college district, with the same course or instructor proposal. The school district may not be prohibited from establishing a new partnership agreement with the community college district if the course request, instructor, or course documentation changes.

(110 ILCS 27/25)

Sec. 25. Oversight, review, and reporting.

(a) The Illinois Community College Board shall be responsible for oversight and review of dual credit programs offered jointly by public community colleges and high schools. The Illinois Community College Board shall implement a review process and criteria for evaluating dual credit program quality based upon the standards enumerated in Section 20 of this Act.

(b) The Board of Higher Education shall be responsible for oversight and review of dual credit programs offered jointly by high schools and postsecondary institutions, except for public community colleges as provided in subsection (a) of this Section. The Board of Higher Education shall develop and implement a review process based on the standards enumerated in Section 20 of this Act.

(c) Each postsecondary institution shall report annually to the appropriate agency, the Illinois Community College Board or the Board of Higher Education. The reports shall include, but not be limited to, the following data:

(1) Number and description of dual credit courses.

(2) Faculty teaching dual credit courses and their academic credentials.

(3) Enrollments in dual credit courses.

(4) Sites of dual credit offerings.

(d) Each postsecondary institution shall file an electronic copy of any dual credit agreement executed or amended on or after the effective date of this amendatory Act of the 104th General Assembly within 30 days after execution or amendment with the Board of Higher Education or Illinois Community College Board, as appropriate. The Illinois Community College Board shall publish all dual credit agreements between school districts and out-of-state or private postsecondary institutions on its website.

(Source: P.A. 96-194, eff. 1-1-10.)

(110 ILCS 27/45 new)

Sec. 45. State and federal law and administrative rule requirements. All postsecondary institutions and school districts shall ensure that dual credit courses, instructors, and course documentation meet requirements established by State and federal law and administrative rules adopted by State agencies and are aligned with the Higher Learning Commission or other applicable accreditation agencies.

(110 ILCS 27/50 new)

Sec. 50. Study. Five years after the effective date of this amendatory Act of the 104th General Assembly, the Illinois Community College Board shall conduct a study concerning the impact of the changes made by this amendatory Act of the 104th General Assembly, including, but not limited to, the impact on postsecondary enrollment, persistence, completion, quality, and access to dual credit in Illinois. The study shall include student demographics. The study shall be submitted to the General Assembly and the Governor by October 1, 2030 and published on the Illinois Community College Board's website.

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 bill, as amended, was ordered to a third reading.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Castro, **House Bill No. 2967** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 57; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Wilcox
Curran	Holmes	Rezin	Mr. President

DeWitte	Hunter	Rose
Edly-Allen	Johnson	Simmons
Ellman	Jones, E.	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 in the Senate Amendments adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Fine, **House Bill No. 3019** was recalled from the order of third reading to the order of second reading.

Senator Fine offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 3019

AMENDMENT NO. 2 . Amend House Bill 3019, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 356z.14, 356z.40, and 370c and by adding Section 355.7 as follows:

(215 ILCS 5/355.7 new)

Sec. 355.7. Medical loss ratio report and premium rebate.

(a) A health insurance issuer offering group or individual health insurance coverage, including a grandfathered health plan, shall, with respect to each plan year, submit to the Director a report concerning the ratio of the incurred loss or incurred claims plus the loss adjustment expense or change in contract reserves to earned premiums. The report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends:

(1) on reimbursement for clinical services provided to enrollees under such coverage;

(2) for activities that improve health care quality; and

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding federal and State taxes and licensing or regulatory fees.

(b) A health insurance issuer shall comply with subsection (a) by filing with the Director a copy of the report submitted to the United States Department of Health and Human Services under 42 U.S.C. 300gg-18, which must comply with federal regulations promulgated thereunder. The Department shall make the reports received under this Section available to the public on its website.

(c) If 42 U.S.C. 300gg-18 or the federal regulations promulgated thereunder are amended after January 15, 2025 to repeal the reporting or rebate requirements, reduce the amount or types of information required to be reported, or adopt a calculation method that reduces the amount of rebates in this State, a health insurance issuer shall file a supplemental report with the Director or make supplemental rebate payments, as applicable, for group or individual health insurance coverage regulated by this State to ensure that the same total information is filed with the Director and the same total rebates are remitted to enrollees as before the federal repeal, reduction, or recalculation took effect.

(d) Notwithstanding any other provision of this Section, under no circumstances may the costs described in paragraphs (1) and (2) of subsection (a) include:

(1) executive compensation beyond base salary;

(2) entity surplus or accumulated profit; or

(3) costs attendant with an application for lifestyle management, weight loss, or wellness when the application falls outside the scope of 45 CFR 158.140 through 158.160.

(e) This Section does not apply with respect to any policy of excepted benefits as defined under 42 U.S.C. 300gg-91.

(f) Notwithstanding anything in this Section to the contrary, this Section does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(215 ILCS 5/356z.14)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after December 12, 2008 (the effective date of Public Act 95-1005) must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of $36,000 per year~~,~~ but shall not be subject to any limits on the number of visits to a service provider. The ~~After December 30, 2009, the~~ Director of ~~the Division of~~ Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or the individual's ~~their~~ dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this Section.

(e-5) An insurer may not deny or refuse to provide otherwise covered services under a group or individual policy of accident and health insurance or a managed care plan solely because of the location wherein the clinically appropriate services are provided.

(f) Upon request of the ~~reimbursing~~ insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated. Nothing in this subsection supersedes the prohibition on prior authorization for mental health treatment under subsection (w) of Section 370c.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Adm. Code 500 and any subsequent amendments thereto.

(h-5) If an individual has been diagnosed as having an autism spectrum disorder, meeting the diagnostic criteria in place at the time of diagnosis, and treatment is determined medically necessary, then that individual shall remain eligible for coverage under this Section even if subsequent changes to the diagnostic criteria are adopted by the American Psychiatric Association. If no changes to the diagnostic criteria are adopted after April 1, 2012, and before December 31, 2014, then this subsection (h-5) shall be of no further force and effect.

(h-10) An insurer may not deny or refuse to provide covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract, for a person diagnosed with an autism spectrum disorder on the basis that the individual declined an alternative medication or covered service when the individual's health care provider has determined that such medication or covered service

may exacerbate clinical symptomatology and is medically contraindicated for the individual and the individual has requested and received a medical exception as provided for under Section 45.1 of the Managed Care Reform and Patient Rights Act. For the purposes of this subsection (h-10), "clinical symptomatology" means any indication of disorder or disease when experienced by an individual as a change from normal function, sensation, or appearance.

(h-15) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage outlined in subsection (h-10), then subsection (h-10) is inoperative with respect to all coverage outlined in subsection (h-10) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in subsection (h-10).

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service, or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, disease, or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

(2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, 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. 102-322, eff. 1-1-22; 103-154, eff. 6-30-23; revised 7-23-24.)

(215 ILCS 5/356z.40)

(Text of Section before amendment by P.A. 103-701 and 103-720)

Sec. 356z.40. Pregnancy and postpartum coverage.

(a) An individual or group policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after October 8, 2021 (the effective date of Public Act 102-665) ~~this amendatory Act of the 102nd General Assembly~~ shall provide coverage for pregnancy and newborn care in accordance with 42 U.S.C. 18022(b) regarding essential health benefits.

(b) Benefits under this Section shall be as follows:

(1) An individual who has been identified as experiencing a high-risk pregnancy by the individual's treating provider shall have access to clinically appropriate case management programs. As used in this subsection, "case management" means a mechanism to coordinate and assure continuity of services, including, but not limited to, health services, social services, and educational services necessary for the individual. "Case management" involves individualized assessment of needs, planning of services, referral, monitoring, and advocacy to assist an individual in gaining access to appropriate services and closure when services are no longer required. "Case management" is an active and collaborative process involving a single qualified case manager, the individual, the individual's family, the providers, and the community. This includes close coordination and involvement with all service providers in the management plan for that individual or family, including assuring that the individual receives the services. As used in this subsection, "high-risk pregnancy" means a pregnancy in which the pregnant or postpartum individual or baby is at an increased risk for poor health or complications during pregnancy or childbirth, including, but not limited to, hypertension disorders, gestational diabetes, and hemorrhage.

(2) An individual shall have access to medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the requirements set forth in this Section and in Sections 370c and 370c.1 of this Code. Prior authorization requirements are prohibited to the extent provided in Section 370c.

(3) The benefits provided for inpatient and outpatient services for the medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided ~~if determined to be medically necessary,~~ consistent with the requirements of Sections 370c and 370c.1 of this Code. The facility or provider shall notify the insurer of both the admission and the initial treatment plan within 48 hours after admission or initiation of treatment. Subject to the requirements of Sections 370c and 370c.1 of this Code, nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review of health care services, including review of medical necessity, case management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy.

(4) The benefits for the first 48 hours of initiation of services for an inpatient admission, detoxification or withdrawal management program, or partial hospitalization admission for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided without post-service or concurrent review of medical necessity, as the medical necessity for the first 48 hours of such services shall be determined solely by the covered pregnant or postpartum individual's provider. Subject to Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review, including the review of medical necessity, case management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy, of any inpatient admission, detoxification or withdrawal management program admission, or partial hospitalization admission services for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications received 48 hours after the initiation of such services. If an insurer determines that the services are no longer medically necessary, then the covered person shall have the right to external review pursuant to the requirements of the Health Carrier External Review Act.

(5) If an insurer determines that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment in a facility is no longer medically necessary, the insurer shall, within 24 hours, provide written notice to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider of its decision and the right to file an expedited internal appeal of the determination. The insurer shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider. If the determination is to uphold the denial, the covered

pregnant or postpartum individual and the covered pregnant or postpartum individual's provider have the right to file an expedited external appeal. An independent review organization shall make a determination within 72 hours. If the insurer's determination is upheld and it is determined that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment is not medically necessary, or if the insurer's determination is not appealed, the insurer shall remain responsible for providing benefits for the inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment through the day following the date the determination is made, and the covered pregnant or postpartum individual shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the policy. The covered pregnant or postpartum individual shall not be discharged or released from the inpatient facility, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment until all internal appeals and independent utilization review organization appeals are exhausted. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(6) Except as otherwise stated in this subsection (b), the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the policy.

(7) The benefits required by paragraphs (2) and (6) of this subsection (b) are to be provided to all covered pregnant or postpartum individuals with a diagnosis of a mental, emotional, nervous, or substance use disorder or condition. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection (b).

(Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25; revised 9-10-24.)

(Text of Section after amendment by P.A. 103-701 and 103-720)

Sec. 356z.40. Pregnancy and postpartum coverage.

(a) An individual or group policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after October 8, 2021 (the effective date of Public Act 102-665) shall provide coverage for pregnancy and newborn care in accordance with 42 U.S.C. 18022(b) regarding essential health benefits. For policies amended, delivered, issued, or renewed on or after January 1, 2026, this subsection also applies to coverage for postpartum care.

(b) Benefits under this Section shall be as follows:

(1) An individual who has been identified as experiencing a high-risk pregnancy by the individual's treating provider shall have access to clinically appropriate case management programs. As used in this subsection, "case management" means a mechanism to coordinate and assure continuity of services, including, but not limited to, health services, social services, and educational services necessary for the individual. "Case management" involves individualized assessment of needs, planning of services, referral, monitoring, and advocacy to assist an individual in gaining access to appropriate services and closure when services are no longer required. "Case management" is an active and collaborative process involving a single qualified case manager, the individual, the individual's family, the providers, and the community. This includes close coordination and involvement with all service providers in the management plan for that individual or family, including assuring that the individual receives the services. As used in this subsection, "high-risk pregnancy" means a pregnancy in which the pregnant or postpartum individual or baby is at an increased risk for poor health or complications during pregnancy or childbirth, including, but not limited to, hypertension disorders, gestational diabetes, and hemorrhage.

(2) An individual shall have access to medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the requirements set forth in this Section and in Sections 370c and 370c.1 of this Code. Prior authorization requirements are prohibited to the extent provided in Section 370c.

(3) The benefits provided for inpatient and outpatient services for the medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided ~~if determined to be medically necessary,~~ consistent with the requirements of Sections 370c and 370c.1 of this Code. The facility or provider shall notify the insurer of both the admission and the initial treatment plan within 48 hours after admission or initiation of treatment. Subject to the requirements of Sections 370c and 370c.1 of this Code, nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review

of health care services, including review of medical necessity, case management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy.

(4) The benefits for the first 48 hours of initiation of services for an inpatient admission, detoxification or withdrawal management program, or partial hospitalization admission for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided without post-service or concurrent review of medical necessity, as the medical necessity for the first 48 hours of such services shall be determined solely by the covered pregnant or postpartum individual's provider. Subject to Sections ~~Section~~ 370c and 370c.1 of this Code, nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review, including the review of medical necessity, case management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy, of any inpatient admission, detoxification or withdrawal management program admission, or partial hospitalization admission services for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications received 48 hours after the initiation of such services. If an insurer determines that the services are no longer medically necessary, then the covered person shall have the right to external review pursuant to the requirements of the Health Carrier External Review Act.

(5) If an insurer determines that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment in a facility is no longer medically necessary, the insurer shall, within 24 hours, provide written notice to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider of its decision and the right to file an expedited internal appeal of the determination. The insurer shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider. If the determination is to uphold the denial, the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider have the right to file an expedited external appeal. An independent review organization shall make a determination within 72 hours. If the insurer's determination is upheld and it is determined that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment is not medically necessary, or if the insurer's determination is not appealed, the insurer shall remain responsible for providing benefits for the inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment through the day following the date the determination is made, and the covered pregnant or postpartum individual shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the policy. The covered pregnant or postpartum individual shall not be discharged or released from the inpatient facility, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment until all internal appeals and independent utilization review organization appeals are exhausted. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(6) Except as otherwise stated in this subsection (b) and subsection (c), the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the policy.

(7) The benefits required by paragraphs (2) and (6) of this subsection (b) are to be provided to (i) all covered pregnant or postpartum individuals with a diagnosis of a mental, emotional, nervous, or substance use disorder or condition and (ii) all individuals who have experienced a miscarriage or stillbirth. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection (b).

(8) Insurers shall cover all services for pregnancy, postpartum, and newborn care that are rendered by perinatal doulas or licensed certified professional midwives, including home births, home visits, and support during labor, abortion, or miscarriage. Coverage shall include the necessary equipment and medical supplies for a home birth. For home visits by a perinatal doula, not counting any home birth, the policy may limit coverage to 16 visits before and 16 visits after a birth, miscarriage, or abortion, provided that the policy shall not be required to cover more than $8,000 for doula visits for each pregnancy and subsequent postpartum period. As used in this paragraph (8),

"perinatal doula" has the meaning given in subsection (a) of Section 5-18.5 of the Illinois Public Aid Code.

(9) Coverage for pregnancy, postpartum, and newborn care shall include home visits by lactation consultants and the purchase of breast pumps and breast pump supplies, including such breast pumps, breast pump supplies, breastfeeding supplies, and feeding aids as recommended by the lactation consultant. As used in this paragraph (9), "lactation consultant" means an International Board-Certified Lactation Consultant, a certified lactation specialist with a certification from Lactation Education Consultants, or a certified lactation counselor as defined in subsection (a) of Section 5-18.10 of the Illinois Public Aid Code.

(10) Coverage for postpartum services shall apply for all covered services rendered within the first 12 months after the end of pregnancy, subject to any policy limitation on home visits by a perinatal doula allowed under paragraph (8) of this subsection (b). Nothing in this paragraph (10) shall be construed to require a policy to cover services for an individual who is no longer insured or enrolled under the policy. If an individual becomes insured or enrolled under a new policy, the new policy shall cover the individual consistent with the time period and limitations allowed under this paragraph (10). This paragraph (10) is subject to the requirements of Section 25 of the Managed Care Reform and Patient Rights Act, Section 20 of the Network Adequacy and Transparency Act, and 42 U.S.C. 300gg-113.

(c) All coverage described in subsection (b), other than health care services for home births, shall be provided without cost-sharing, except that, for mental health services, the cost-sharing prohibition does not apply to inpatient or residential services, and, for substance use disorder services, the cost-sharing prohibition applies only to levels of treatment below and not including Level 3.1 (Clinically Managed Low-Intensity Residential), as established by the American Society for Addiction Medicine. This subsection does not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code.

(Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25; 103-701, eff. 1-1-26; 103-720, eff. 1-1-26; revised 11-26-24.)

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

Sec. 370c. Mental and emotional disorders.

(a)(1) On and after January 1, 2022 (the effective date of Public Act 102-579), every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness ~~on an expense-incurred basis~~ shall provide coverage for the medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions consistent with the parity requirements of Section 370c.1 of this Code.

(2) Each insured that is covered for mental, emotional, nervous, or substance use disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act of his or her choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his or her profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, licensed speech-language pathologists, and other licensed or certified professionals at programs licensed pursuant to the Substance Use Disorder Act, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act has informed the patient of the desirability of the patient conferring with the patient's primary care physician.

(4) "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 World Health Organization's International Classification of Disease or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. "Mental, emotional, nervous, or substance use disorder or condition" includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(5) Medically necessary treatment and medical necessity determinations shall be interpreted and made in a manner that is consistent with and pursuant to subsections (h) through (y) ~~(t)~~.

(b)(1) (Blank).

(2) (Blank).

(2.5) (Blank).

(3) Unless otherwise prohibited by federal law and consistent with the parity requirements of Section 370c.1 of this Code, the ~~reimbursing~~ insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. Nothing in this paragraph (3) supersedes the prohibition on prior authorization requirements to the extent provided under subsections (g) and (w) and subparagraph (A) of paragraph (6.5) of this subsection. ~~An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure.~~ Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for mental, emotional, nervous, or substance use disorders or conditions, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders.

(4) A group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024) or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall provide coverage based upon medical necessity for the treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the parity requirements of Section 370c.1 of this Code; provided, however, that in each calendar year coverage shall not be less than the following:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A); and

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan.

(C) (Blank).

(5) An issuer of a group health benefit plan or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of

medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(5.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after September 9, 2015 (the effective date of Public Act 99-480) shall offer coverage for medically necessary acute treatment services and medically necessary clinical stabilization services. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

As used in this subsection:

"Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

"Clinical stabilization services" means 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

"Prior authorization" has the meaning given to that term in Section 15 of the Prior Authorization Reform Act.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(6.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall not impose prior authorization requirements, including limitations on dosage, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine, on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(B) shall not impose any step therapy requirements;

(C) shall place all prescription medications approved by the United States Food and Drug Administration prescribed or administered for the treatment of substance use disorders on, for brand medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers brand medications and, for generic medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers generic medications; and

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

(7) (Blank).

(8) (Blank).

(9) With respect to all mental, emotional, nervous, or substance use disorders or conditions, coverage for inpatient treatment shall include coverage for treatment in a residential treatment center certified or licensed by the Department of Public Health or the Department of Human Services.

(c) This Section shall not be interpreted to require coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.15 of this Code.

(d) With respect to a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace, the Department and, with respect to medical assistance, the Department of Healthcare and Family Services shall each enforce the requirements of this Section and Sections 356z.23 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under, those Acts, including, but not limited to, 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. Specifically, the Department and the Department of Healthcare and Family Services shall take action:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses, as set forth in paragraph (6) of subsection (k) of Section 370c.1, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental, emotional, nervous, or substance use disorder or condition coverage for possible parity violations;

(3) performing parity compliance market conduct examinations or, in the case of the Department of Healthcare and Family Services, parity compliance audits of individual and group plans and policies, including, but not limited to, reviews of:

(A) nonquantitative treatment limitations, including, but not limited to, prior authorization requirements, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates, and geographic restrictions;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the Department.

The findings and the conclusions of the parity compliance market conduct examinations and audits shall be made public.

The Director may adopt rules to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(e) Availability of plan information.

(1) The criteria for medical necessity determinations made under a group health plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) The reason for any denial under a group health benefit plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace (or health insurance coverage offered in connection with such plan or policy) of reimbursement or payment for services with respect to mental, emotional, nervous, or substance use disorders or conditions benefits in the case of any participant or beneficiary must be made available within a reasonable time and in a reasonable manner and in readily understandable language by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary upon request.

(f) As used in this Section, "group policy of accident and health insurance" and "group health benefit plan" includes (1) State-regulated employer-sponsored group health insurance plans written in Illinois or which purport to provide coverage for a resident of this State; and (2) State, county, municipal, or school district employee health plans. References to an insurer include all plans described in this subsection.

(g) (1) As used in this subsection:

"Benefits", with respect to insurers that are not Medicaid managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (High-Intensity Outpatient) ~~(Partial Hospitalization)~~, 3.1 (Clinically Managed Low-Intensity Residential), ~~3.3 (Clinically Managed Population-Specific High-Intensity Residential),~~ 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential ~~Monitored Intensive Inpatient~~) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to Medicaid managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (High-Intensity Outpatient) ~~(Partial Hospitalization)~~, 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential ~~Monitored Intensive Inpatient~~) and OMT (Opioid Maintenance Therapy) services.

"Substance use disorder treatment provider or facility" means a licensed physician, licensed psychologist, licensed psychiatrist, licensed advanced practice registered nurse, or licensed, certified, or otherwise State-approved facility or provider of substance use disorder treatment.

(2) A group health insurance policy, an individual health benefit plan, or qualified health plan that is offered through the health insurance marketplace, small employer group health plan, and large employer group health plan that is amended, delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, on or after January 1, 2019 (the effective date of Public Act 100-1023) shall comply with the requirements of this Section and Section 370c.1. The services for the treatment and the ongoing assessment of the patient's progress in treatment shall follow the requirements of 77 Ill. Adm. Code 2060.

(3) Prior authorization shall not be utilized for the benefits under this subsection. Except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification, the insurer may require the ~~The~~ substance use disorder treatment provider or facility to ~~shall~~ notify the insurer of the initiation of treatment. For an insurer that is not a Medicaid managed care organization, the substance use disorder treatment provider or facility may be required to give notification ~~shall occur~~ for the initiation of treatment of the covered person within 2 business days. For Medicaid managed care organizations, the substance use disorder treatment provider or facility may be required to give notification ~~shall occur~~ in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization. Treatment plans shall be developed in accordance with the requirements and timeframes established in 77 Ill. Adm. Code 2060. No such coverage shall be subject to concurrent review prior to the applicable notification deadline. If coverage is denied retrospectively, neither the provider or facility nor the insurer shall bill, and the covered individual shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the treatment or stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for benefits that were furnished at a participating substance use disorder facility prior to the applicable notification deadline except for the following: ~~If the substance use disorder treatment provider or facility fails to notify the insurer of the initiation of treatment in accordance with these provisions, the insurer may follow its normal prior authorization processes.~~

(A) upon reasonable determination that the benefits were not provided;

(B) upon determination that the patient receiving the treatment was not an insured, enrollee, or beneficiary under the policy;

(C) upon material misrepresentation by the patient or provider. As used in this subparagraph (C), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation;

(D) upon determination that a service was excluded under the terms of coverage. For situations that qualify under this subparagraph (D), the limitation to billing for a copayment, coinsurance, or deductible shall not apply;

(E) upon determination that a service was not medically necessary consistent with subsections (h) through (n); or

(F) upon determination that the patient did not consent to the treatment and that there was no court order mandating the treatment.

(4) For an insurer that is not a Medicaid managed care organization, if an insurer determines that benefits are no longer medically necessary, the insurer shall notify the covered person, the covered person's authorized representative, if any, and the covered person's health care provider in writing of the covered person's right to request an external review pursuant to the Health Carrier External Review Act. The notification shall occur within 24 hours following the adverse determination.

Pursuant to the requirements of the Health Carrier External Review Act, the covered person or the covered person's authorized representative may request an expedited external review. An expedited external review may not occur if the substance use disorder treatment provider or facility determines that continued treatment is no longer medically necessary.

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization shall make a final determination of medical necessity within 72 hours. If

an independent review organization upholds an adverse determination, an insurer shall remain responsible to provide coverage of benefits through the day following the determination of the independent review organization. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(5) The substance use disorder treatment provider or facility shall provide the insurer with 7 business days' advance notice of the planned discharge of the patient from the substance use disorder treatment provider or facility and notice on the day that the patient is discharged from the substance use disorder treatment provider or facility.

(6) The benefits required by this subsection shall be provided to all covered persons with a diagnosis of substance use disorder or conditions. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection.

(7) Nothing in this subsection shall be construed to require an insurer to provide coverage for any of the benefits in this subsection.

(8) Any concurrent or retrospective review permitted by this subsection must be consistent with the utilization review provisions in subsections (h) through (n).

(h) As used in this Section:

"Generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities in a manner that is all of the following:

(1) in accordance with the generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

"Utilization review" means either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to insureds.

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

"Utilization review criteria" means patient placement criteria or any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

(i)(1) 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 and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2023 shall, pursuant to subsections (h) through (s), provide coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions.

(2) An insurer shall not set a specific limit on the duration of benefits or coverage of medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions or limit coverage only to alleviation of the insured's current symptoms.

(3) All utilization review conducted by the insurer concerning diagnosis, prevention, and treatment of insureds diagnosed with mental, emotional, nervous, or substance use disorders or conditions shall be conducted in accordance with the requirements of subsections (k) through (w).

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this Section shall not rescind or modify the authorization after that provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent cancellation or modification of the insured's or policyholder's contract, or the insured's or policyholder's eligibility. Nothing in this Section shall require the insurer to cover a treatment when the authorization was granted based on a material misrepresentation by the insured, the policyholder, or the provider. Nothing in this Section shall require Medicaid managed care organizations to pay for services if the individual was not eligible for Medicaid at the time the service was rendered. Nothing in this Section shall require an insurer to pay for services if the individual was not the insurer's enrollee at the time services were rendered. As used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results in or could result in a substantial change in the situation.

(j) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program. Nothing in this subsection shall be construed to require an insurer to cover benefits that have been authorized and provided for a covered person by a public entitlement program. Medicaid managed care organizations are not subject to this subsection.

(k) An insurer shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care. All denials and appeals shall be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.

(l) In conducting utilization review of all covered health care services for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions, an insurer shall apply the criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty or, for Medicaid managed care organizations, criteria and guidelines determined by the Department of Healthcare and Family Services that are consistent with generally accepted standards of mental, emotional, nervous or substance use disorder or condition care. Pursuant to subsection (b), in conducting utilization review of all covered services and benefits for the diagnosis, prevention, and treatment of substance use disorders an insurer shall use the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine.

(m) In conducting utilization review relating to level of care placement, continued stay, transfer, discharge, or any other patient care decisions that are within the scope of the sources specified in subsection (l), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the assessment of the insured using the relevant patient placement criteria as specified in subsection (l). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its assessment using the relevant criteria as specified in subsection (l) to the provider of the service and the patient.

If an insurer purchases or licenses utilization review criteria pursuant to this subsection, the insurer shall verify and document before use that the criteria were developed in accordance with subsection (k).

(n) In conducting utilization review that is outside the scope of the criteria as specified in subsection (l) or relates to the advancements in technology or in the types or levels of care that are not addressed in the most recent versions of the sources specified in subsection (l), an insurer shall conduct utilization review in accordance with subsection (k).

(o) This Section does not in any way limit the rights of a patient under the Medical Patient Rights Act.

(p) This Section does not in any way limit early and periodic screening, diagnostic, and treatment benefits as defined under 42 U.S.C. 1396d(r).

(q) To ensure the proper use of the criteria described in subsection (l), every insurer shall do all of the following:

(1) Educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the utilization review criteria.

(2) Make the educational program available to other stakeholders, including the insurer's participating or contracted providers and potential participants, beneficiaries, or covered lives. The education program must be provided at least once a year, in-person or digitally, or recordings of the education program must be made available to the aforementioned stakeholders.

(3) Provide, at no cost, the utilization review criteria and any training material or resources to providers and insured patients upon request. For utilization review criteria not concerning level of care placement, continued stay, transfer, discharge, or other patient care decisions used by the insurer pursuant to subsection (m), the insurer may place the criteria on a secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access to insureds or their providers. No restrictions shall be placed upon the insured's or treating provider's access right to utilization review criteria obtained under this paragraph at any point in time, including before an initial request for authorization.

(4) Track, identify, and analyze how the utilization review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making that covers how medical necessity decisions are made; this assessment shall cover all aspects of utilization review as defined in subsection (h).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(8) Maintain documentation of interrater reliability testing and the remediation actions taken for those with pass rates lower than 90% and submit to the Department of Insurance or, in the case of Medicaid managed care organizations, the Department of Healthcare and Family Services the testing results and a summary of remedial actions as part of parity compliance reporting set forth in subsection (k) of Section 370c.1.

(r) This Section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions covered by an insurance policy, including prescription drugs.

(s) This Section applies to 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 conducts utilization review as defined in this Section, including Medicaid managed care organizations, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(t) If the Director determines that an insurer has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty between $1,000 and $5,000 for each violation. Moneys collected from penalties shall be deposited into the Parity Advancement Fund established in subsection (i) of Section 370c.1.

(u) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this Section.

(v) The provisions of this Section are severable. If any provision of this Section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(w) Beginning January 1, 2026, coverage for medically necessary treatment of mental, emotional, or nervous disorders or conditions ~~for inpatient mental health treatment at participating hospitals~~ shall comply with the following requirements:

(1) No ~~Subject to paragraphs (2) and (3) of this subsection, no~~ policy shall require prior authorization for outpatient or partial hospitalization services for treatment of mental, emotional, or nervous disorders or conditions provided by a physician licensed to practice medicine in all branches,

a licensed clinical psychologist, a licensed clinical social worker, a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed speech-language pathologist, or any other type of licensed, certified, or legally authorized provider, including trainees working under the supervision of a licensed health care professional listed under this subsection, or facility whose outpatient or partial hospitalization services the policy covers for treatment of mental, emotional, or nervous disorders or conditions. Such coverage may be subject to concurrent and retrospective review consistent with the utilization review provisions in subsections (h) through (n) and Section 370c.1. Nothing in this paragraph (1) supersedes a health maintenance organization's referral requirement for services from nonparticipating providers. An insurer may require providers or facilities to notify the insurer of the initiation of treatment as specified in this subsection, except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification. No such coverage shall be subject to concurrent review for any services furnished before an applicable notification deadline, subject to the following: ~~admission for such treatment at any participating hospital.~~

(A) In the case of outpatient treatment, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification deadline of 2 business days after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol within the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care organization.

(B) In the case of a partial hospitalization program, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification deadline of 48 hours after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care organization.

(2) No policy shall require prior authorization for inpatient treatment at a hospital for mental, emotional, or nervous disorders or conditions at a participating provider. Additionally, no such coverage shall ~~Coverage provided under this subsection also shall not~~ be subject to concurrent review for the first 72 hours after admission, provided that the provider ~~hospital~~ must notify the insurer of both the admission and the initial treatment plan within 48 hours of admission. A discharge plan must be fully developed and continuity services prepared to meet the patient's needs and the patient's community preference upon release. ~~Nothing in this paragraph supersedes a health maintenance organization's referral requirement for services from nonparticipating providers upon a patient's discharge from a hospital.~~ Recommended level of care placements identified in the discharge plan shall comply with generally accepted standards of care, as defined in subsection (h).

(A) If the provider satisfies the conditions of paragraph (2), then the insurer shall approve coverage of the recommended level of care, if applicable, upon discharge subject to concurrent review.

(B) Nothing in this paragraph supersedes a health maintenance organization's referral requirement for services from nonparticipating providers upon a patient's discharge from a hospital or facility.

(C) Concurrent review for such coverage must be consistent with the utilization review provisions in subsections (h) through (n).

(D) In this subsection, residential treatment that is not otherwise identified in the discharge plan is not inpatient hospitalization.

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating provider ~~hospital~~ shall bill, and the insured shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for the first 72 hours of admission to inpatient hospitalization for treatment of mental, emotional, or nervous disorders or conditions, or before the applicable deadline under paragraph (1) of this subsection for outpatient treatment or partial hospitalization programs, ~~treatment~~ at a participating provider ~~hospital~~ except:

(A) upon reasonable determination that the inpatient mental health treatment was not provided;

(B) upon determination that the patient receiving the treatment was not an insured, enrollee, or beneficiary under the policy;

(C) upon material misrepresentation by the patient or health care provider. In this item (C), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation; ~~or~~

(D) upon determination that a service was excluded under the terms of coverage. In that case, the limitation to billing for a copayment, coinsurance, or deductible shall not apply;~~.~~

(E) for outpatient treatment or partial hospitalization programs only, upon determination that a service was not medically necessary consistent with subsections (h) through (n); or

(F) upon determination that the patient did not consent to the treatment and that there was no court order mandating the treatment.

~~(4)~~ Nothing in this subsection shall be construed to require a policy to cover any health care service excluded under the terms of coverage.

This subsection does not apply to coverage for any prescription or over-the-counter drug.

Nothing in this subsection shall be construed to require the medical assistance program to reimburse for services not covered by the medical assistance program as authorized by the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(x) Notwithstanding any provision of this Section, nothing shall require the medical assistance program under Article V of the Illinois Public Aid Code or the Children's Health Insurance Program Act to violate any applicable federal laws, regulations, or grant requirements, including requirements for utilization management, or any State or federal consent decrees. Nothing in subsection (g) or ~~subsection~~ (w) shall prevent the Department of Healthcare and Family Services from requiring a health care provider to use specified level of care, admission, continued stay, or discharge criteria, including, but not limited to, those under Section 5-5.23 of the Illinois Public Aid Code, as long as the Department of Healthcare and Family Services, subject to applicable federal laws, regulations, or grant requirements, including requirements for utilization management, does not require a health care provider to seek prior authorization or concurrent review from the Department of Healthcare and Family Services, a Medicaid managed care organization, or a utilization review organization under the circumstances expressly prohibited by subsections (g) and ~~subsection~~ (w). Nothing in this Section prohibits a health plan, including a Medicaid managed care organization, from conducting reviews for medical necessity, clinical appropriateness, safety, fraud, waste, or abuse and reporting suspected fraud, waste, or abuse according to State and federal requirements. Nothing in this Section limits the authority of the Department of Healthcare and Family Services or another State agency, or a Medicaid managed care organization on the State agency's behalf, to (i) implement or require programs, services, screenings, assessments, tools, or reviews to comply with applicable federal law, federal regulation, federal grant requirements, any State or federal consent decrees or court orders, or any applicable case law, such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii) administer or require programs, services, screenings, assessments, tools, or reviews established under State or federal laws, rules, or regulations in compliance with State or federal laws, rules, or regulations, including, but not limited to, the Children's Mental Health Act and the Mental Health and Developmental Disabilities Administrative Act.

(y) (Blank). ~~Children's Mental Health. Nothing in this Section shall suspend the screening and assessment requirements for mental health services for children participating in the State's medical assistance program as required in Section 5-5.23 of the Illinois Public Aid Code.~~

(Source: P.A. 102-558, eff. 8-20-21; 102-579, eff. 1-1-22; 102-813, eff. 5-13-22; 103-426, eff. 8-4-23; 103-650, eff. 1-1-25; 103-1040, eff. 8-9-24; revised 11-26-24.)

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

(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.

(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 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 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 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 give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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, 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.

(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.

(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 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.

(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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days after a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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.

(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 or 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 (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) 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 women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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.

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

(1) The 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. 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.

(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).

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

(d-5)(1) Every 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), insurers who are not able to comply with the provider ratios and time and distance standards established 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(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) 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 insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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, 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.

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

(1) The 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. 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.

(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).

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

(d-5)(1) Every 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), insurers who are not able to comply with the provider ratios and time and distance standards established 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(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.

(a) 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 women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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, 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.

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

(1) The 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.

(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) 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 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).

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 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(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) 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 women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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, 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.

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

(1) The 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. 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 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).

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

(d-5)(1) Every 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), insurers who are not able to comply with the provider ratios and time and distance standards established 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(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.)

Section 15. 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, 355.7, 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, 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, 355.7, 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, 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; 103-808, 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 20. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows: (215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355.7, 355b, 355d, 356g, 356g.5, 356g.5-1, 356m, 356q, 356r, 356t, 356u, 356u.10, 356v, 356w, 356x, 356y, 356z.1, 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.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.32a, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.71, 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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; 102-203, eff. 1-1-22; 102-306, 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; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-656, 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; 103-832, eff. 1-1-25; 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 Illinois Public Aid Code is amended by changing Section 5-5.28 as follows:

(305 ILCS 5/5-5.28 new)

Sec. 5-5.28. Rulemaking authority. The Department of Healthcare and Family Services may adopt rules to implement the applicable provisions of this amendatory Act of the 104th General Assembly to managed care organizations, managed care community networks, and, at the Department's discretion, any other managed care entity described in subsection (i) of Section 5-30 of the Illinois Public Aid Code and the medical assistance fee-for-service program.

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 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.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Fine, **House Bill No. 3019** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 45; NAYS 11.

The following voted in the affirmative:

Aquino	Feigenholtz	Jones, E.	Sims
Balkema	Fine	Joyce	Stadelman

Belt	Glowiak Hilton	Koehler	Turner, D.
Castro	Guzmán	Lewis	Ventura
Cervantes	Halpin	Martwick	Villa
Collins	Harris, N.	Morrison	Villanueva
Cunningham	Harriss, E.	Murphy	Villivalam
Curran	Hastings	Peters	Walker
DeWitte	Hills	Porfirio	Mr. President
Edly-Allen	Holmes	Preston	
Ellman	Hunter	Rezin	
Faraci	Johnson	Simmons	

The following voted in the negative:

Anderson	Chesney	Plummer	Tracy
Arellano, L.	Fowler	Rose	Wilcox
Bryant	McClure	Syverson	

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 in the Senate Amendments adopted thereto.

READING BILL OF THE SENATE A THIRD TIME

On motion of Senator Harmon, **Senate Bill No. 2510** 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 31; NAYS 19.

The following voted in the affirmative:

Aquino	Feigenholtz	Koehler	Stadelman
Castro	Fine	Martwick	Ventura
Cervantes	Guzmán	Morrison	Villa
Collins	Harris, N.	Murphy	Villanueva
Cunningham	Holmes	Peters	Villivalam
Edly-Allen	Hunter	Porfirio	Walker
Ellman	Johnson	Simmons	Mr. President
Faraci	Jones, E.	Sims	

The following voted in the negative:

Anderson	Curran	Lewis	Syverson
Arellano, L.	DeWitte	McClure	Tracy
Balkema	Fowler	Plummer	Turner, S.
Bryant	Harriss, E.	Rezin	Wilcox
Chesney	Hills	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.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Belt, **House Bill No. 2987** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 2; Present 2.

The following voted in the affirmative:

Aquino	Feigenholtz	Jones, E.	Stadelman
Balkema	Fine	Joyce	Syverson
Belt	Fowler	Koehler	Tracy
Bryant	Glowiak Hilton	Martwick	Turner, D.
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	Wilcox
Ellman	Hunter	Simmons	Mr. President
Faraci	Johnson	Sims	

The following voted in the negative:

Arellano, L.
Chesney

The following voted present:

Anderson
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 in the Senate Amendment adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Harmon, **House Bill No. 2568** was recalled from the order of third reading to the order of second reading.

Senator Harmon offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 2568

AMENDMENT NO. 2 . Amend House Bill 2568, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. References to Act. This Act may be referred to as the Equality for Every Family Act.

Section 5. The Illinois Parentage Act of 2015 is amended by changing Sections 102, 103, 105, 107, 201, 204, 205, 301, 302, 303, 305, 401, 402, 403, 404, 405, 407, 408, 501, 502, 601, 602, 603, 604, 605, 606, 608, 609, 610, 612, 614, 615, 617, 621, 622, 702, 703, 704, 705, 707, 708, 709, 710, and 903 and by adding Section 704.5 as follows:

(750 ILCS 46/102)

Sec. 102. Public policy. Illinois recognizes the right of every child to the physical, mental, emotional, and financial support of a parent or ~~his or her~~ parents. The parent-child relationship, including support obligations, extends equally to every child and to the child's ~~his or her~~ parent or to each of the child's ~~his or her~~ 2 parents, regardless of the legal relationship of the parents, and regardless of whether a parent is a minor. A child shall have the same rights and protections under law to parentage without regard to the marital status, age, gender, gender identity or sexual orientation of their parents or the circumstances of the child's birth, including whether the child was born as a result of assisted reproduction or surrogacy.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/103)

Sec. 103. Definitions. In this Act:

(a) "Acknowledged parent ~~father~~" means a person ~~man~~ who has established a parent-child ~~father-child~~ relationship under Article 3.

(b) "Adjudicated parent ~~father~~" means a person ~~man~~ who has been adjudicated by a court of competent jurisdiction, or as authorized under Article X of the Illinois Public Aid Code, to be the parent ~~father~~ of a child.

(c) "Alleged genetic parent ~~father~~" means a person ~~man~~ who alleges ~~himself~~ to be, or is alleged to be, a genetic parent ~~the biological father or a possible biological father~~ of a child~~, but~~ whose parentage ~~paternity~~ has not been adjudicated ~~established~~. The term does not include:

(1) a presumed parent or acknowledged parent ~~father~~; ~~or~~

(2) a person ~~man~~ whose parental rights have been terminated or declared not to exist; or

(3) a donor.

(d) "Assisted reproduction" means a method of achieving a pregnancy through means other than by sexual intercourse, including, but not limited to, all of the following: (1) artificial insemination or intrauterine, intracervical, or vaginal insemination; (2) donation of gametes; (3) donation of embryos; (4) in vitro fertilization and embryo transfer; (5) intracytoplasmic sperm injection; or (6) assisted reproductive technology ~~an artificial insemination or an embryo transfer and includes gamete and embryo donation~~. "Assisted reproduction" does not include any pregnancy achieved through sexual intercourse.

(e) "Child" means an individual of any age whose parentage may be established under this Act.

(f) "Combined parentage ~~paternity~~ index" means the likelihood of parentage ~~paternity~~ calculated by computing the ratio between:

(1) the likelihood that the tested person ~~man~~ is the parent ~~father~~, based on the genetic markers of the tested person, woman or person who gave birth ~~man, mother~~, and child, conditioned on the hypothesis that the tested person ~~man~~ is the parent ~~father~~ of the child; and

(2) the likelihood that the tested person ~~man~~ is not the parent ~~father~~, based on the genetic markers of the tested person, woman or person who gave birth ~~man, mother~~, and child, conditioned on the hypothesis that the tested person ~~man~~ is not the parent ~~father~~ of the child and that the parent of the child ~~father~~ is of the same ethnic or racial group as the tested person ~~man~~.

(g) "Commence" means to file the initial pleading seeking an adjudication of parentage in the circuit court of this State.

(h) "Determination of parentage" means the establishment of the parent-child relationship by the signing of a voluntary acknowledgment under Article 3 of this Act or adjudication by the court or as authorized under Article X of the Illinois Public Aid Code.

(i) "Donor" means a person who provides gametes intended for use in assisted reproduction, whether or not for compensation. "Donor" does not include a person who is a parent under Article 7 or an intended parent under the Gestational Surrogacy Act ~~an individual who participates in an assisted reproductive technology arrangement by providing gametes and relinquishes all rights and responsibilities to the gametes so that another individual or individuals may become the legal parent or parents of any resulting child. "Donor" does not include a spouse in any assisted reproductive technology arrangement in which his or her spouse will parent any resulting child~~.

(j) "Ethnic or racial group" means, for purposes of genetic testing, a recognized group that an individual identifies as all or part of the individual's ancestry or that is so identified by other information.

(k) "Gamete" means either a sperm or an egg.

(l) "Genetic testing" means an analysis of genetic markers to exclude or identify a person ~~man~~ as the parent ~~father or a woman as the mother~~ of a child as provided in Article 4 of this Act.

(l-5) "Gestational surrogacy" means the process by which a woman or person attempts to carry and give birth to a child created through in vitro fertilization in which the gestational surrogate has made no genetic contribution to any resulting child.

(m) "Gestational surrogate" means a woman or person who is not an intended parent and agrees to engage in a gestational surrogacy arrangement pursuant to the terms of a valid gestational surrogacy arrangement under the Gestational Surrogacy Act.

(m-5) "Intended parent" means a person ~~person~~ who consents to ~~enters into an~~ assisted reproduction ~~reproductive technology arrangement~~, including a gestational surrogacy agreement, such that the person is a ~~arrangement, under which he or she will be the~~ legal parent ~~parent~~ of the resulting child. "Intended parent" includes, in the case of a married couple, both spouses for all purposes under this Act.

(n) "Parent" means an individual who has established a parent-child relationship under Section 201 of this Act.

(o) "Parent-child relationship" means the legal relationship between a child and a parent of the child.

(p) "Presumed parent" means an individual who, by operation of law under Section 204 of this Act, is recognized as the parent of a child unless ~~until~~ that status is rebutted or confirmed in a judicial or administrative proceeding.

(q) "Probability of parentage ~~paternity~~" means the measure, for the ethnic or racial group to which the alleged genetic parent ~~father~~ belongs, of the probability that the person ~~man~~ in question is the parent ~~father~~ of the child, compared with a random, unrelated person and ~~man~~ of the same ethnic or racial group, expressed as a percentage incorporating the combined parentage ~~paternity~~ index and a prior probability.

(r) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(s) "Signatory" means an individual who authenticates a record and is bound by its terms.

(t) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(u) "Substantially similar legal relationship" means a relationship recognized in this State under Section 60 of the Illinois Religious Freedom Protection and Civil Union Act.

(v) "Support-enforcement agency" means a public official or agency authorized to seek:

(1) enforcement of support orders or laws relating to the duty of support;

(2) establishment or modification of child support;

(3) determination of parentage; or

(4) location of child-support obligors and their income and assets.

(Source: P.A. 99-85, eff. 1-1-16; 99-763, eff. 1-1-17; 99-769, eff. 1-1-17; 100-201, eff. 8-18-17.)

(750 ILCS 46/105)

Sec. 105. Authority to establish parentage. The circuit courts are authorized to establish parentage under this Act. The Department of Healthcare and Family Services may make an administrative determination of parentage or non-parentage ~~determinations of paternity and nonpaternity~~ in accordance with Section 10-17.7 of the Illinois Public Aid Code. Such administrative determinations shall have the full force and effect of court judgments entered under this Act.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/107)

Sec. 107. Applicability. Insofar as practicable, the provisions of this Act applicable to the parent ~~father~~ and child relationship shall apply equally without regard to gender ~~to the mother and child relationship~~ including, but not limited to, the obligation to support.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/201)

Sec. 201. Establishment of parent-child relationship.

(a) The parent-child relationship is established between a person ~~woman~~ and a child by:

(1) the woman or person having given birth to the child, except as otherwise provided in the Gestational Surrogacy Act;

(2) a presumption of the person's parentage of the child under Section 204 of this Act unless the presumption is overcome in a judicial proceeding or a valid denial of parentage is made under Section 303 of this Act ~~an adjudication of the woman's parentage~~;

(3) an effective voluntary acknowledgment of parentage by the person under Article 3 of this Act, unless the acknowledgment has been rescinded or successfully challenged ~~adoption of the child by the woman~~;

(4) an adjudication of the person's parentage; ~~a valid gestational surrogacy arrangement that complies with the Gestational Surrogacy Act or other law; or~~

(5) the person's adoption of the child; ~~an unrebutted presumption of the woman's parentage of the child under Section 204 of this Act~~

(6) the person's consent to assisted reproduction under Article 7 of this Act; or

(7) the person's parentage of the child is established under the provisions of the Gestational Surrogacy Act.

(b) (Blank). ~~The parent-child relationship is established between a man and a child by:~~

~~(1) an unrebutted presumption of the man's parentage of the child under Section 204 of this Act;~~

~~(2) an effective voluntary acknowledgment of paternity by the man under Article 3 of this Act, unless the acknowledgment has been rescinded or successfully challenged;~~

~~(3) an adjudication of the man's parentage;~~

~~(4) adoption of the child by the man; or~~

~~(5) a valid gestational surrogacy arrangement that complies with the Gestational Surrogacy Act or other law.~~

(c) (Blank). ~~Insofar as practicable, the provisions of this Act applicable to parent-child relationships shall apply equally to men and women as parents, including, but not limited to, the obligation to support.~~

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/204)

Sec. 204. Presumption of parentage.

(a) A person is presumed to be the parent of a child if:

(1) the person and the woman or person who gave birth to ~~mother of~~ the child have entered into a marriage, civil union, or substantially similar legal relationship, and the child is born, to the woman or person who gave birth to the child, ~~mother~~ during the marriage, civil union, or substantially similar legal relationship, except as provided in the Gestational Surrogacy Act or other law;

(2) the person and the woman or person who gave birth to ~~mother of~~ the child were in a marriage, civil union, or substantially similar legal relationship and the child is born, to the woman or person who gave birth to the child, ~~mother~~ within 300 days after the marriage, civil union, or substantially similar legal relationship is terminated by death, declaration of invalidity of marriage, judgment for dissolution of marriage, civil union, or substantially similar legal relationship, or after a judgment for legal separation, except as provided in the Gestational Surrogacy Act or other law;

(3) before the birth of the child, the person and the woman or person who gave birth to ~~mother of~~ the child entered into a marriage, civil union, or substantially similar legal relationship in apparent compliance with law, even if the attempted marriage, civil union, or substantially similar legal relationship is or could be declared invalid, and the child is born during the invalid marriage, civil union, or substantially similar legal relationship or within 300 days after its termination by death, declaration of invalidity of marriage, judgment for dissolution of marriage, civil union, or substantially similar legal relationship, or after a judgment for legal separation, except as provided in the Gestational Surrogacy Act or other law; or

(4) after the child's birth, the person and the woman or person who gave birth to the child ~~child's mother~~ have entered into a marriage, civil union, or substantially similar legal relationship, even if the marriage, civil union, or substantially similar legal relationship is or could be declared invalid, and the person is named, with the person's written consent, as the child's parent on the child's birth certificate.

(b) If 2 or more conflicting presumptions arise under this Section, the presumption which on the facts is founded on the weightier considerations of policy and logic, especially the policy of promoting the child's best interests, controls. In weighing the presumptions, the court shall consider the factors enumerated in paragraph (3) of subsection (a) of Section 610.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/205)

Sec. 205. Proceedings to declare the non-existence of the parent-child relationship.

(a) An action to declare the non-existence of the parent-child relationship may be brought by the child, the woman or person who gave birth to the child ~~mother~~, or a person presumed to be a parent under Section 204 of this Act. Actions brought by the child, the woman or person who gave birth to the child

~~mother~~, or a presumed parent shall be brought by verified complaint, which shall be designated a petition. After a presumption under Section 204 of this Act has been rebutted, parentage of the child by another person ~~man or woman~~ may be established in the same action, if such person ~~he or she~~ has been made a party.

(b) An action to declare the non-existence of the parent-child relationship brought under subsection (a) of this Section shall be barred if brought later than 2 years after the petitioner knew or should have known of the relevant facts. The 2-year period for bringing an action to declare the non-existence of the parent-child relationship shall not extend beyond the date on which the child reaches the age of 18 years. Failure to bring an action within 2 years shall not bar any party from asserting a defense in any action to declare the existence of the parent-child relationship.

(c) An action to declare the non-existence of the parent-child relationship may be brought subsequent to an adjudication of parentage in any judgment by the person ~~man~~ adjudicated to be the parent pursuant to a presumption in paragraphs (a)(1) through (a)(4) of Section 204 if, as a result of deoxyribonucleic acid (DNA) testing, it is discovered that the person ~~man~~ adjudicated to be the parent is not the parent ~~father~~ of the child. Actions brought by the adjudicated parent ~~father~~ shall be brought by verified petition. If, as a result of the deoxyribonucleic acid (DNA) testing that is admissible under Section 614 of this Act, the petitioner is determined not to be the parent ~~father~~ of the child, the adjudication of parentage ~~paternity~~ and any orders regarding the allocation of parental responsibilities, parenting time, and future payments of support may be vacated. This provision shall not apply to actions involving parentage of children born through assisted reproduction.

(d) An action to declare the non-existence of the parent-child relationship brought under subsection (c) of this Section shall be barred if brought more than 2 years after the petitioner obtains actual knowledge of relevant facts. The 2-year period shall not apply to periods of time where the woman or person who gave birth to the child ~~mother~~ or the child refuses to submit to deoxyribonucleic acid (DNA) testing. The 2-year period for bringing an action to declare the non-existence of the parent-child relationship shall not extend beyond the date on which the child reaches the age of 18 years.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/301)

Sec. 301. Voluntary acknowledgment. A parent-child relationship may be established voluntarily by the signing and witnessing of a voluntary acknowledgment in accordance with Section 12 of the Vital Records Act and Section 10-17.7 of the Illinois Public Aid Code. A woman or person who gave birth to a child and an alleged genetic parent of the child, a presumed parent under Section 204, or an intended parent under Article 7, may sign an acknowledgment of parentage to establish the parentage of the child. The voluntary acknowledgment shall contain the social security numbers or tax identification numbers of the persons signing the voluntary acknowledgment; however, failure to include the social security numbers of the persons signing a voluntary acknowledgment does not invalidate the voluntary acknowledgment.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/302)

Sec. 302. Execution of voluntary acknowledgment.

(a) A voluntary acknowledgment described in Section 301 of this Act must:

(1) be in a record;

(2) be signed, or otherwise authenticated, under penalty of perjury by the woman or person who gave birth to the child ~~mother~~ and by the person ~~man~~ seeking to establish ~~his~~ parentage;

(3) state that the child whose parentage is being acknowledged:

(A) does not have a presumed parent, or has a presumed parent whose full name is stated; and

(B) does not have another acknowledged or adjudicated parent;

(4) be witnessed; and

(5) state that the signatories understand that the voluntary acknowledgment is the equivalent of a judicial adjudication of parentage of the child and that: (i) a challenge by a signatory to the voluntary acknowledgment may be permitted only upon a showing of fraud, duress, or material mistake of fact; and (ii) a challenge to the voluntary acknowledgment is barred after 2 years unless that period is tolled pursuant to the law.

(b) An acknowledgment is void if it:

(1) states that another person is a presumed parent, unless a denial signed or otherwise authenticated by the presumed parent is filed with the Department of Healthcare and Family Services, as provided by law;

(2) states that another person is an acknowledged or adjudicated parent; or

(3) falsely denies the existence of a presumed, acknowledged, or adjudicated parent of the child.

(c) A presumed parent ~~father~~ may sign or otherwise authenticate a voluntary acknowledgment.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/303)

Sec. 303. Denial of parentage. A presumed parent may sign a denial of parentage. The denial is valid only if:

(a) a voluntary acknowledgment described in Section 301 of this Act signed, or otherwise authenticated, by a person ~~man~~ is filed pursuant to Section 305 of this Act;

(b) the denial is in a record, and is signed, or otherwise authenticated, under penalty of perjury; and

(c) the presumed parent has not previously:

(1) acknowledged ~~his~~ parentage, unless the previous voluntary acknowledgment has been rescinded under Section 307 of this Act or successfully challenged under Section 308 of this Act; or

(2) been adjudicated to be the parent of the child.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/305)

Sec. 305. Effect of voluntary acknowledgment or denial of parentage.

(a) Except as otherwise provided in Sections 307 and 308 of this Act, a valid voluntary acknowledgment filed with the Department of Healthcare and Family Services, as provided by law, is equivalent to an adjudication of the parentage of a child and confers upon the acknowledged parent ~~father~~ all of the rights and duties of a parent.

(b) Notwithstanding any other provision of this Act, parentage established in accordance with Section 301 of this Act has the full force and effect of a judgment entered under this Act and serves as a basis for seeking a child support order without any further proceedings to establish parentage.

(c) Except as otherwise provided in Sections 307 and 308 of this Act, a valid denial by a presumed parent filed with the Department of Healthcare and Family Services, as provided by law, in conjunction with a voluntary acknowledgment, is equivalent to an adjudication of the nonparentage of the presumed parent and discharges the presumed parent from all rights and duties of a parent.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/401)

Sec. 401. Proceeding authorized.

(a) As soon as practicable, a court, or an administrative hearing officer in an Expedited Child Support System may, subject to subsection (c), order or direct a woman or person who gave birth to the child, the child, and an alleged, acknowledged parent, adjudicated parent, or the presumed parent to submit to deoxyribonucleic acid (DNA) testing to determine inherited characteristics.

(b) A court, or an administrative hearing officer in an Expedited Child Support System, upon the request of any party, or the child, shall, subject to subsection (c), order or direct a woman or person who gave birth to the child, the child, and a presumed, acknowledged, alleged, or adjudicated parent to submit to deoxyribonucleic acid (DNA) testing to determine inherited characteristics unless the court determines that (1) the conduct of the parent, acknowledged parent, adjudicated parent, or the presumed parent estops that party from denying parentage; (2) it would be inequitable to disprove the parent-child relationship between the child and the presumed, acknowledged, or adjudicated parent, and (3) that it is in the child's best interest to deny DNA testing considering the factors in Section 610(a)(3). It is presumed to be equitable and in the best interest of the child to grant a motion by the child seeking an order for genetic testing. The presumption may be overcome by clear and convincing evidence that extraordinary circumstances exist making the genetic testing contrary to the child's best interests. The court's order denying a child's request for genetic testing must state the basis upon which the presumption was overcome. The court's order granting a child's request for genetic testing must specify the ways in which testing results may be used for purposes of protecting the child's best interests. In a proceeding involving the application of this Section, a minor or incapacitated child must be represented by a guardian ad litem, child's representative, or attorney for the child.

(c) Genetic testing may not be used to (1) challenge the parentage of a person who is a parent under Article 7 or the Gestational Surrogacy Act, inclusive, or (2) establish the parentage of a person who is a donor.

~~As soon as practicable, a court or an administrative hearing officer in an Expedited Child Support System may, and upon the request of a party except as provided in Section 610 of this Act, or of the child, shall order or direct the mother, child, and alleged father to submit to deoxyribonucleic acid (DNA) testing to determine inherited characteristics. If any party refuses to submit to genetic testing, the court may resolve the question of paternity against that party or enforce its order if the rights of others and the interests of justice so require.~~

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/402)

Sec. 402. Requirements for genetic testing.

(a) The genetic testing shall be conducted by an expert qualified as an examiner of blood or tissue types and appointed by the court. The expert shall determine the genetic testing procedures. However, any interested party, for good cause shown, in advance of the scheduled genetic testing, may request a hearing to object to the qualifications of the expert or the genetic testing procedures. The expert appointed by the court shall testify at the pre-test hearing at the expense of the party requesting the hearing, except for an indigent party as provided in Section 405 of this Act. An expert not appointed by the court shall testify at the pre-test hearing at the expense of the party retaining the expert. Inquiry into an expert's qualifications at the pre-test hearing shall not affect either party's right to have the expert qualified at trial.

(b) Genetic testing must be of a type reasonably relied upon by experts in the field of genetic testing and performed in a testing laboratory accredited by the American Association of Blood Banks or a successor to its functions.

(c) A specimen used in genetic testing may consist of one or more samples, or a combination of samples, of blood, buccal cells, bone, hair, or other body tissue or fluid.

(d) The testing laboratory shall determine the databases from which to select frequencies for use in calculation of the probability of parentage ~~paternity~~ based on the ethnic or racial group of an individual or individuals. If there is disagreement as to the testing laboratory's choice, the following rules apply:

(1) The individual objecting may require the testing laboratory, within 30 days after receipt of the report of the genetic testing, to recalculate the probability of parentage ~~paternity~~ using an ethnic or racial group different from that used by the laboratory.

(2) The individual objecting to the testing laboratory's initial choice shall:

(A) if the frequencies are not available to the testing laboratory for the ethnic or racial group requested, provide the requested frequencies compiled in a manner recognized by accrediting bodies; or

(B) engage another testing laboratory to perform the calculations.

(e) If, after recalculation using a different ethnic or racial group, genetic testing does not reputably identify a person ~~man~~ as the parent ~~father~~ of a child, an individual who has been tested may be required to submit to additional genetic testing.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/403)

Sec. 403. Genetic test results.

(a) The expert shall prepare a written report of the genetic test results. If the genetic test results show that the alleged genetic parent ~~father~~ is not excluded, the report shall contain statistics based upon the statistical formula of combined parentage ~~paternity~~ index (CPI) and the probability of parentage ~~paternity~~ as determined by the probability of exclusion (Random Person ~~Man~~ Not Excluded = RPNE ~~RMNE~~). The expert may be called by the court as a witness to testify to the expert's ~~his or her~~ findings and, if called, shall be subject to cross-examination by the parties. If the genetic test results show that the alleged genetic parent ~~father~~ is not excluded, any party may demand that other experts, qualified as examiners of blood or tissue types, perform independent genetic testing under order of court, including, but not limited to, blood types or other testing of genetic markers. The results of the genetic testing may be offered into evidence. The number and qualifications of the experts shall be determined by the court.

(b) Documentation of the chain of custody of the blood or tissue samples, accompanied by an affidavit or certification in accordance with Section 1-109 of the Code of Civil Procedure, is competent evidence to establish the chain of custody.

(c) The report of the genetic test results prepared by the appointed expert shall be made by affidavit or by certification as provided in Section 1-109 of the Code of Civil Procedure and shall be mailed to all parties. A proof of service shall be filed with the court. The verified report shall be admitted into evidence at trial without foundation testimony or other proof of authenticity or accuracy, unless a written motion challenging the admissibility of the report is filed by either party within 28 days of receipt of the report, in which case expert testimony shall be required. A party may not file such a motion challenging the admissibility of the report later than 28 days before commencement of trial. Before trial, the court shall determine whether the motion is sufficient to deny admission of the report by verification. Failure to make that timely motion constitutes a waiver of the right to object to admission by verification and shall not be grounds for a continuance of the hearing to establish parentage ~~paternity~~.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/404)

Sec. 404. Effect of genetic testing. Genetic testing taken under this Article shall have the following effect:

(a) If the court finds that the conclusion of the expert or experts, as disclosed by the evidence based upon the genetic testing, is that the alleged genetic parent ~~father~~ is not the parent of the child, the question of parentage ~~paternity~~ shall be resolved accordingly.

(b) If the experts disagree in their findings or conclusions, the question shall be weighed with other competent evidence of parentage ~~paternity~~.

(c) If the genetic testing results indicate that the alleged genetic parent ~~father~~ is not excluded and that the combined parentage ~~paternity~~ index is at least 1,000 to 1, and there is at least a 99.9% probability of parentage ~~paternity~~, the alleged genetic parent ~~father~~ is presumed to be the parent ~~father~~, and this evidence shall be admitted.

(d) A person ~~man~~ identified under subsection (c) of this Section as the parent ~~father~~ of the child may rebut the genetic testing results by other genetic testing satisfying the requirements of this Article which:

(1) excludes the person ~~man~~ as a genetic parent ~~father~~ of the child; or

(2) identifies another person ~~man~~ as the possible parent ~~father~~ of the child.

(e) Except as otherwise provided in this Article, if more than one person ~~man~~ is identified by genetic testing as the possible parent ~~father~~ of the child, the court shall order them to submit to further genetic testing to identify the genetic parent ~~father~~.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/405)

Sec. 405. Cost of genetic testing. The expense of the genetic testing shall be paid by the party who requests the genetic testing, except that the court may apportion the costs between the parties, upon request. When the genetic testing is requested by the party seeking to establish parentage ~~paternity~~ and that party is found to be indigent by the court, the expense shall be paid by the public agency providing representation; except that where a public agency is not providing representation, the expense shall be paid by the county in which the action is brought. When the genetic testing is ordered by the court on its own motion or is requested by the alleged or presumed parent ~~father~~ and that parent ~~father~~ is found to be indigent by the court, the expense shall be paid by the county in which the action is brought. Any part of the expense may be taxed as costs in the action, except that no costs may be taxed against a public agency that has not requested the genetic testing.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/407)

Sec. 407. Independent genetic testing. Nothing in this Article shall prevent a party from obtaining genetic testing of the party's ~~his or her~~ own blood or tissue independent of those ordered by the court or from presenting expert testimony interpreting those tests or any other blood tests ordered under this Article. Reports of all the independent tests, accompanied by affidavit or certification pursuant to Section 1-109 of the Code of Civil Procedure, and notice of any expert witnesses to be called to testify to the results of those tests shall be submitted to all parties at least 30 days before any hearing set to determine the issue of parentage.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/408)

Sec. 408. Additional persons to be tested.

(a) Subject to subsection (b), if a genetic-testing specimen is not available from a person ~~man~~ who may be the parent ~~father~~ of a child, for good cause and under circumstances the court considers to be just, the court may order the following individuals to submit specimens for genetic testing:

(1) the parents of the person ~~man~~;

(2) brothers and sisters of the person ~~man~~;

(3) other children of the person and the woman or person who gave birth to the person ~~man and their mothers~~; and

(4) other relatives of the person ~~man~~ necessary to complete genetic testing.

(b) Issuance of an order under this Section requires a finding that a need for genetic testing outweighs the legitimate interests of the individual sought to be tested, and in no event shall an order be issued until the individual is joined as a party and given notice as required under the Code of Civil Procedure.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/501)

Sec. 501. Temporary orders.

(a) On a motion by a party and a showing of clear and convincing evidence of parentage, the court shall issue a temporary order for support of a child, including a non-minor child with a disability, if the order is appropriate and the individual ordered to pay support is:

(1) a presumed parent of the child;

(2) petitioning to have parentage adjudicated;

(3) identified as the parent ~~father~~ through genetic testing under Article 4 of this Act;

(4) an alleged genetic parent ~~father~~ who has declined to submit to genetic testing;

(5) shown by clear and convincing evidence to be the child's parent ~~father~~;

(6) the woman or person who gave birth to ~~mother of~~ the child except under the Gestational Surrogacy Act; or

(7) anyone else determined to be the child's parent.

In determining the amount of a temporary child support award, the court shall use the guidelines and standards set forth in Sections 505, 505.2, and 513.5 of the Illinois Marriage and Dissolution of Marriage Act.

(b) A temporary order may include provisions for the allocation of parental responsibilities and parenting time as provided by the Illinois Marriage and Dissolution of Marriage Act. A temporary order may, in accordance with the provisions of subsection (a) of Section 508 of the Illinois Marriage and Dissolution of Marriage Act that relate to proceedings other than pre-judgment dissolution proceedings, include an award for interim attorney's fees and costs.

(c) Temporary orders issued under this Section shall not have prejudicial effect with respect to final child support, the allocation of parental responsibilities, or parenting time orders.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/502)

Sec. 502. Injunctive relief.

(a) In any action brought under this Act for the initial determination of parentage, the allocation of parental responsibilities or parenting time, or for modification of a prior allocation order or judgment or parenting time order, the court, upon application of a party, may enjoin a party having physical possession or an allocation order or judgment from temporarily relocating the child from this State pending the adjudication of the issues of parentage, the allocation of parental responsibilities, and parenting time. When deciding whether to enjoin relocation of a child, or to order a party to return the child to this State, the court shall consider factors including, but not limited to:

(1) the extent of previous involvement with the child by the party seeking to enjoin relocation or to have the absent party return the child to this State;

(2) the likelihood that parentage will be established; and

(3) the impact on the financial, physical, and emotional health of the party being enjoined from relocating the child or the party being ordered to return the child to this State.

(b) A temporary restraining order or preliminary injunction under this Act shall be governed by the relevant provisions of Part 1 of Article XI of the Code of Civil Procedure.

(c) Notwithstanding the provisions of subsection (a) of this Section, the court may decline to enjoin a domestic violence victim having physical possession or an allocation order or judgment from temporarily or permanently relocating the child from this State pending an allocation of parental responsibilities or an

adjudication of parenting time. In determining whether a person is a domestic violence victim, the court shall consider the following factors:

(1) a sworn statement by the person that the person has good reason to believe that the person ~~he or she~~ is the victim of domestic violence or stalking;

(2) a sworn statement that the person fears for the person's ~~his or her~~ safety or the safety of the person's ~~his or her~~ children;

(3) evidence from police, court, or other government agency records or files;

(4) documentation from a domestic violence program if the person is alleged to be a victim of domestic violence;

(5) documentation from a legal, clerical, medical, or other professional from whom the person has sought assistance in dealing with the alleged domestic violence; and

(6) any other evidence that supports the sworn statements, such as a statement from any other individual with knowledge of the circumstances that provides the basis for the claim, or physical evidence of the domestic violence.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/601)

Sec. 601. Proceeding authorized. A civil proceeding may be maintained to adjudicate the parentage of a child. The proceeding is governed by the Code of Civil Procedure and Illinois Supreme Court Rules. Administrative proceedings adjudicating parentage ~~paternity~~ shall be governed by Section 10-17.7 of the Illinois Public Aid Code.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/602)

Sec. 602. Standing. A complaint to adjudicate parentage shall be verified, shall be designated a petition, and shall name the person or persons alleged to be the parent of the child. Subject to Article 3 and Sections 607, 608, and 609 of this Act, a proceeding to adjudicate parentage may be maintained by:

(a) the child;

(b) the woman or person who gave birth to ~~mother of~~ the child;

(c) a pregnant woman or person;

(d) a person ~~man~~ presumed or alleged ~~alleging himself~~ to be the parent of the child;

~~(e) a woman presumed or alleging herself to be the parent of the child;~~

(e) ~~(f)~~ the support-enforcement agency or other governmental agency authorized by other law;

(f) ~~(g)~~ any person or public agency that has physical possession of or has custody of or has been allocated parental responsibilities for, is providing financial support to, or has provided financial support to the child;

(g) ~~(h)~~ the Department of Healthcare and Family Services if it is providing, or has provided, financial support to the child or if it is assisting with child support collections services;

(h) ~~(i)~~ an authorized adoption agency or licensed child welfare agency;

(i) ~~(j)~~ a representative authorized by law to act for an individual who would otherwise be entitled to maintain a proceeding but who is deceased, incapacitated, or a minor; or

(j) ~~(k)~~ an intended parent.

(Source: P.A. 103-501, eff. 1-1-24.)

(750 ILCS 46/603)

Sec. 603. Subject matter and personal jurisdiction.

(a) The circuit courts of this State shall have jurisdiction of an action brought under this Act. In a civil action not brought under this Act, the provisions of this Act shall apply if parentage is at issue. The court may join any action under this Act with any other civil action in which this Act is applicable.

(b) An individual may not be adjudicated to be a parent unless the court has personal jurisdiction over the individual.

(c) A court of this State having jurisdiction to adjudicate parentage may exercise personal jurisdiction over a nonresident individual, or the guardian or conservator of the individual, if the conditions prescribed in Section 201 of the Uniform Interstate Family Support Act exist, including, but not limited to: if the individual engaged in sexual intercourse in this State and the child may have been conceived by that act of intercourse; the individual consented to assisted reproduction that occurred in this State that resulted in the conception of the child; if the individual consented to a medical procedure that occurred in this State related to assisted reproduction that resulted in the conception of the child; if the child was born or is anticipated to be born in this State; an individual consented to a mental health consultation that occurred in this State

pursuant to the Gestational Surrogacy Act, or there is any other basis consistent with the constitutions of this State and the United States for the exercise of personal jurisdiction ~~are fulfilled~~.

(d) Lack of jurisdiction over one individual does not preclude the court from making an adjudication of parentage binding on another individual over whom the court has personal jurisdiction.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/604)

Sec. 604. Venue.

(a) Venue for a proceeding to adjudicate parentage is any county of this State in which a party resides, or if the presumed parent or alleged genetic parent ~~father~~ is deceased, in which a proceeding for probate or administration of the presumed parent's or alleged genetic parent's ~~father's~~ estate has been commenced, or could be commenced.

(b) A proceeding for the allocation of parental responsibilities is commenced in the county where the child resides.

(c) A parentage proceeding under the Gestational Surrogacy Act or Article 7 of this Act may be commenced in any county in this State.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/605)

Sec. 605. Notice to presumed parent.

(a) Except in cases governed under the Gestational Surrogacy Act, the petitioner shall give notice of a proceeding to adjudicate parentage to the following individuals:

(1) the woman or individual who gave birth to the child, unless a court has adjudicated that the woman or individual is not a parent;

(2) an individual who is a parent of the child under this Act;

(3) a presumed, acknowledged, or adjudicated parent of the child; and

(4) an individual whose parentage is to be adjudicated.

(b) An individual entitled to notice under subsection (a) has a right to intervene in the proceeding.

(c) Lack of notice required by subsection (a) does not render a judgment void. Lack of notice does not preclude an individual entitled to notice under subsection (a) from bringing a proceeding under subsection (b) of Section 609.

(d) A ~~In any action brought under Article 3 or Article 6 of this Act where the individual signing the petition for an order establishing the existence of the parent-child relationship by consent or the individual alleged to be the parent in a petition is different from an individual who is presumed to be the parent of the child under Article 2 of this Act, a~~ notice required by this Section shall be served on the individual ~~presumed parent~~ in the same manner as summonses are served in other civil proceedings or, in lieu of personal service, service may be made as follows:

(1) The petitioner ~~person requesting notice~~ shall pay to the clerk of the circuit court a mailing fee of $1.50 and furnish to the clerk of the circuit court an original and one copy of a notice together with an affidavit setting forth the individual's ~~presumed parent's~~ last known address. The original notice shall be retained by the clerk of the circuit court.

(2) The clerk of the circuit court shall promptly mail to the individual ~~presumed parent~~, at the address appearing in the affidavit, the copy of the notice by certified mail, return receipt requested. The envelope and return receipt shall bear the return address of the clerk of the circuit court. The receipt for certified mail shall state the name and address of the addressee and the date of mailing and shall be attached to the original notice.

(3) The return receipt, when returned to the clerk of the circuit court, shall be attached to the original notice and shall constitute proof of service.

(4) The clerk of the circuit court shall note the fact of service in a permanent record.

(e) ~~(b)~~ The notice shall read as follows:

"IN THE MATTER OF NOTICE TO ..... INDIVIDUAL ~~PRESUMED PARENT~~.

You have been identified as an individual with a claim to parentage ~~the presumed parent~~ of ....., born on ..... The woman or person who gave birth to ~~birth parent of~~ the child is .....

An action is being brought to establish the parent-child relationship between the named child and a parent named by the person filing this action, ...

You may ~~As the presumed parent, you~~ have certain legal rights with respect to the named child, including the right to notice of the filing of proceedings instituted for the establishment of parentage of the named child and, in some situations ~~if named as a parent in a petition to establish parentage~~, the right to

submit to, along with the woman or person who gave birth to the child ~~birth parent~~ and the child, deoxyribonucleic acid (DNA) tests to determine inherited characteristics, subject to Section 401 ~~610~~ of the Illinois Parentage Act of 2015. If you wish to assert your rights with respect to the child named in this notice, you must file with the Clerk of this Circuit Court of ..... County, Illinois, whose address is ....., within 30 days after the date of receipt of this notice, ~~a declaration of parentage stating that you are, in fact, the parent of the named child and~~ that you intend to assert your legal rights with respect to the child, or that you request to be notified of any further proceedings with respect to the parentage of the child.

If you do not file ~~a declaration of parentage or~~ a request for notice, then you may be later barred from asserting parentage claims ~~whatever legal rights you have~~ with respect to the named child, and ~~including the right to notice of any future proceedings for the establishment of parentage of the child, may be terminated without any further notice to you. When your legal rights with respect to the named child are terminated,~~ you will not be entitled to notice of any future proceedings.".

(f) ~~(c)~~ The notice ~~to a presumed parent~~ under this Section in any action brought by a public agency shall be prepared and mailed by the public agency, and the mailing fee to the clerk of the circuit court shall be waived.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/606)

Sec. 606. Summons. The summons that is served on a respondent shall include the return date on or by which the respondent must appear and shall contain the following information, in a prominent place and in conspicuous language, in addition to the information required to be provided under the laws of this State: "If you do not appear as instructed in this summons, you may be required to support the child named in this petition until the child is at least 18 years old. You may also have to pay the pregnancy and delivery costs of the woman or person who gave birth ~~mother~~.".

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/608)

Sec. 608. Limitation; child having presumed parent.

(a) An action to challenge a presumption of parentage under Section 204 of this Act must be commenced by an individual other than the child ~~An alleged father, as that term is defined in Section 103 of this Act, must commence an action to establish a parent child relationship for a child having a presumed parent~~ not later than 2 years after the petitioner knew or should have known of the relevant facts. The time the petitioner is under legal disability or duress or the ground for relief is fraudulently concealed shall be excluded in computing the period of 2 years. The 2-year limitation does not apply to an action by the child.

(b) A proceeding seeking to declare the non-existence of the parent-child relationship between a child and the child's presumed parent ~~father~~ may be maintained at any time by a person described in paragraphs (1) through (4) of subsection (a) of Section 204 of this Act if the court determines that the presumed parent ~~father~~ and the woman or individual who gave birth to ~~mother of~~ the child neither cohabited nor engaged in sexual intercourse with each other during the probable time of conception.

(c) If in a proceeding to adjudicate a presumed parent's parentage, another individual in addition to the woman or individual who gave birth to the child asserts a claim to parentage of the child, the court shall adjudicate parentage under Section 610. ~~An adjudication under this Section shall serve as a rebuttal or confirmation of a presumed parent as defined in subsection (p) of Section 103.~~

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/609)

Sec. 609. Limitation; child having acknowledged or adjudicated parent.

(a) If a child has an acknowledged parent, a signatory to the acknowledgment described in Section 301 of this Act or related denial may commence a proceeding seeking to challenge the acknowledgment or denial or challenge the parentage ~~paternity~~ of the child only within the time allowed under Section 309 of this Act.

(b) If a child has an acknowledged parent or an adjudicated parent, an individual, other than the child, who is neither a signatory to the acknowledgment nor a party to the adjudication and who seeks to challenge an adjudication of parentage of the child must commence a proceeding not later than 2 years after the effective date of the acknowledgment or adjudication.

(c) A proceeding under this Section is subject to the application of the principles of estoppel established in Section 610 of this Act.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/610)

Sec. 610. Factors in adjudicating parentage ~~Authority to deny motion for genetic testing~~.

(a) Consistent with Sections 205, 309, 608, 609, and 617 in cases in which there are competing claims to parentage and in proceedings ~~In a proceeding~~ in which the parentage of a child having a presumed, acknowledged, or adjudicated parent is at issue, the court shall consider the following factors when adjudicating the individual's parentage ~~may deny a motion by a parent, presumed parent, acknowledged parent, adjudicated parent, alleged parent, or the child seeking an order for genetic testing of the parents and child if the court determines that~~:

(1) whether the conduct of the parent, acknowledged parent, adjudicated parent, or the presumed parent estops that party from denying parentage;

(2) whether it would be inequitable to disprove the parent-child relationship between the child and the presumed, acknowledged, or adjudicated parent; and

(3) whether it is in the child's best interests to adjudicate the individual to be the child's parent ~~to deny genetic testing~~, taking into account the following factors:

(A) the length of time between the current proceeding to adjudicate parentage and the time that the presumed, acknowledged, or adjudicated parent was placed on notice that the presumed, acknowledged, or adjudicated parent ~~he or she~~ might not be the biological parent;

(B) the length of time during which the presumed, acknowledged, or adjudicated parent has assumed the role of parent of the child;

(C) the facts surrounding the presumed, acknowledged, or adjudicated parent's discovery of ~~his or her~~ possible non-parentage ~~nonparentage~~;

(D) the nature of the relationship between the child and the presumed, acknowledged, or adjudicated parent;

(E) the age of the child;

(F) the harm that may result to the child if the presumed, acknowledged, or adjudicated parentage is successfully disproved;

(G) the nature of the relationship between the child and the presumed, acknowledged, adjudicated or alleged parent ~~any alleged parent~~;

(H) the extent to which the passage of time reduces the chances of establishing the parentage of another person and a child support obligation in favor of the child;

(I) other factors that may affect the equities arising from the disruption of the parent-child relationship between the child and the presumed, acknowledged, or adjudicated parent or the chance of other harm to the child; and

(J) any other factors the court determines to be equitable.

(b) In a proceeding involving the application of this Section, a minor or incapacitated child must be represented by a guardian ad litem, child's representative, or attorney for the child. ~~It shall be presumed to be equitable and in the best interests of the child to grant a motion by the child seeking an order for genetic testing. The presumption may be overcome by clear and convincing evidence that extraordinary circumstances exist making the genetic testing contrary to the child's best interests. The court's order denying a child's request for genetic testing must state the basis upon which the presumption was overcome. The court's order granting a child's request for genetic testing must specify the ways in which the testing results may be used for purposes of protecting the child's best interests.~~

(c) (Blank). ~~If the court denies a motion seeking an order for genetic testing, it shall issue an order adjudicating the presumed parent to be the parent of the child.~~

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/612)

Sec. 612. Proceeding before birth. Except as otherwise provided for in this Act, a ~~A~~ proceeding to establish parentage may be commenced before the birth of the child, but may not be concluded until after the birth of the child. The following actions may be taken before the birth of the child:

(a) service of process;

(b) the taking of depositions to perpetuate testimony; and

(c) except as prohibited by Article 4 of this Act, collection of specimens for genetic testing.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/614)

Sec. 614. Admissibility of results of genetic testing; expenses.

(a) Subject to the limitations of Section 401, if ~~If~~ a child has a presumed, acknowledged, or adjudicated parent, the results of genetic testing are inadmissible to adjudicate parentage unless performed:

(1) with the consent of both the woman or person who gave birth to the child ~~mother~~ and the presumed, acknowledged, or adjudicated parent; or

(2) pursuant to an order of the court under Section 401 ~~402~~ of this Act and conducted consistent with Section 402 of this Act.

(b) Copies of bills for genetic testing and for prenatal and postnatal health care for the woman or person who gave birth ~~mother~~ and the child, which are furnished to the adverse party not less than 10 days before the date of a hearing are admissible to establish:

(1) the amount of the charges billed; and

(2) that the charges were reasonable, necessary, and customary.

(c) Certified copies of the bills for costs incurred for pregnancy and childbirth shall be admitted into evidence at judicial or administrative proceedings without foundation testimony or other proof of authenticity or accuracy.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/615)

Sec. 615. Consequences of declining genetic testing.

(a) Subject to the limitations of Section 401, an ~~An~~ order for genetic testing is enforceable through a proceeding for adjudication of contempt.

(b) If an individual whose parentage is being determined declines to submit to genetic testing ordered by the court or administrative agency, the court or administrative agency may adjudicate parentage contrary to the position of that individual.

(c) Genetic testing of the woman or person who gave birth to the ~~mother of a~~ child is not a condition precedent to genetically testing the child and a person ~~man~~ whose parentage ~~paternity~~ is being determined. If the woman or person who gave birth to the child ~~mother~~ is unavailable or declines to submit to genetic testing, the court or administrative agency may order the genetic testing of the child and every person ~~man~~ whose parentage ~~paternity~~ is being adjudicated.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/617)

Sec. 617. Rules for adjudication of parentage of an alleged genetic parent.

(a) In a proceeding involving an alleged genetic parent who is not a presumed parent, if the woman or individual who gave birth to the child is the only other individual with a claim to parentage, the ~~The~~ court shall apply the following rules to adjudicate a claim of ~~the~~ parentage of a child:

~~(a) The parentage of a child having an adjudicated parent may be disproved only by admissible results of genetic testing, or other means, excluding that person as the parent of the child or identifying another person as the parent of the child.~~

(1) ~~(b)~~ Unless the results of the genetic testing or other evidence are admitted to rebut other results of genetic testing, a person identified as the parent of a child under Section 404 of this Act may be adjudicated the parent of the child.

(2)~~(c)~~ If the court finds that genetic testing under Section 404 neither identifies nor excludes a person as the parent of a child, the court may not dismiss the proceeding. In that event, the results of genetic testing and other evidence are admissible to adjudicate the issue of parentage.

(3) ~~(d)~~ Unless the results of genetic testing are admitted to rebut other results of genetic testing, a person excluded as the parent of a child by genetic testing may be adjudicated not to be the parent of the child.

(b) If in a proceeding involving an alleged genetic parent, at least one other individual in addition to the woman or individual who gave birth to the child has a claim to parentage of the child under this Act, the court shall adjudicate parentage under Section 610.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/621)

Sec. 621. Binding effect of determination of parentage.

(a) Except as otherwise provided in subsection (b) of this Section, a determination of parentage is binding on:

(1) all signatories to an acknowledgment or denial as provided in Article 3 of this Act; and

(2) all parties to an adjudication by a court acting under circumstances that satisfy the jurisdictional requirements of Section 201 of the Uniform Interstate Family Support Act.

(b) A child is not bound by a determination of parentage under this Act unless:

(1) the determination was based on an unrescinded acknowledgment as provided in Article 3 of this Act and the acknowledgment is either consistent with the results of genetic testing or for a child born through assisted reproduction;

(2) the adjudication of parentage was based on a finding consistent with the results of genetic testing and the consistency is declared in the determination or is otherwise shown;

(3) the child was a party or was represented in the proceeding determining parentage by a guardian ad litem, child's representative or attorney for the child; ~~and~~

(4) the child was no longer a minor at the time the proceeding was initiated and was the moving party resulting in the parentage determination; and

(5) the determination of parentage was made under Article 7 or the Gestational Surrogacy Act.

(c) In a proceeding for dissolution of marriage, civil union, or substantially similar legal relationship, declaration of invalidity of marriage, civil union, or substantially similar legal relationship, or legal separation, the court is deemed to have made an adjudication of the parentage of a child if the court acts under circumstances that satisfy the jurisdictional requirements of Section 201 of the Uniform Interstate Family Support Act, and the final order:

(1) expressly identifies a child as a "child of the marriage, civil union, or substantially similar legal relationship", "issue of the marriage, civil union, or substantially similar legal relationship", or uses similar words indicating that a party to the marriage, civil union, or substantially similar legal relationship is the parent of the child; or

(2) provides for support of the child by the parties to the marriage, civil union, or substantially similar legal relationship, unless parentage is specifically disclaimed in the order.

(d) Except as otherwise provided in subsection (b) of this Section, a determination of parentage may be a defense in a subsequent proceeding seeking to adjudicate parentage by an individual who was not a party to the earlier proceeding.

(e) A party to an adjudication of parentage may challenge the adjudication only under the laws of this State relating to appeal, vacation of judgments, or other judicial review.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 46/622)

Sec. 622. Allocation of parental responsibilities or parenting time prohibited to persons ~~men~~ who conceive a child ~~father~~ through sexual assault or sexual abuse.

(a) This Section applies to a person who has been found to be the parent ~~father~~ of a child under this Act and who:

(1) has been convicted of or who has pled guilty or nolo contendere to a violation of Section 11-1.20 (criminal sexual assault), Section 11-1.30 (aggravated criminal sexual assault), Section 11-1.40 (predatory criminal sexual assault of a child), Section 11-1.50 (criminal sexual abuse), Section 11-1.60 (aggravated criminal sexual abuse), Section 11-11 (sexual relations within families), Section 12-13 (criminal sexual assault), Section 12-14 (aggravated criminal sexual assault), Section 12-14.1 (predatory criminal sexual assault of a child), Section 12-15 (criminal sexual abuse), or Section 12-16 (aggravated criminal sexual abuse) of the Criminal Code of 1961 or the Criminal Code of 2012, or a similar statute in another jurisdiction, for ~~his~~ conduct in paragraph (1) of this subsection in conceiving ~~fathering~~ that child; or

(2) at a fact-finding hearing, is found by clear and convincing evidence to have committed an act of non-consensual sexual penetration for his conduct in fathering that child.

(b) A person described in subsection (a) shall not be entitled to an allocation of any parental responsibilities or parenting time with that child without the consent of the woman or person who gave birth to the child or the child's ~~mother or~~ guardian. If the person described in subsection (a) is also the guardian of the child, the person ~~he~~ does not have the authority to consent to parenting time or the allocation of parental responsibilities under this Section. If the woman or person who gave birth to ~~mother of~~ the child is a minor, and the person described in subsection (a) is also the parent ~~father~~ or guardian of the woman or person who gave birth to the child ~~mother~~, then the person ~~he~~ does not have the authority to consent to the allocation of parental responsibilities or parenting time.

(c) Notwithstanding any other provision of this Act, nothing in this Section shall be construed to relieve the parent ~~father~~ described in subsection (a) of any support and maintenance obligations to the child under this Act. The woman or person who gave birth to the child or the child's ~~mother or~~ guardian may decline support and maintenance obligations from the parent ~~father~~.

(d) Notwithstanding any other provision of law, the parent ~~father~~ described in subsection (a) of this Section is not entitled to any inheritance or other rights from the child without the consent of the woman or person who gave birth to the child or the child's ~~mother or~~ guardian.

(e) Notwithstanding any provision of the Illinois Marriage and Dissolution of Marriage Act, the parent, grandparent, great-grandparent, or sibling of the person described in subsection (a) of this Section does not have standing to bring an action requesting the allocation of parental responsibilities or parenting time with the child without the consent of the woman or person who gave birth to the child or the child's ~~mother or~~ guardian.

(f) A petition under this Section may be filed by the woman or person who gave birth to the child or the child's ~~mother or~~ guardian either as an affirmative petition in circuit court or as an affirmative defense in any proceeding filed by the person described in subsection (a) of this Section regarding the child.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

(750 ILCS 46/702)

Sec. 702. Parental status of donor. A ~~Except as provided in this Act, a~~ donor is not a parent of a child conceived by means of assisted reproduction.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 46/703)

Sec. 703. Parentage of child of assisted reproduction.

(a) An individual who consents under this Section to assisted reproduction with the intent to be a parent of a child conceived by assisted reproduction is a parent of the child ~~Any individual who is an intended parent as defined by this Act is the legal parent of any resulting child. If the donor and the intended parent have been represented by independent counsel and entered into a written legal agreement in which the donor relinquishes all rights and responsibilities to any resulting child, the intended parent is the parent of the child. An agreement under this subsection shall be entered into prior to any insemination or embryo transfer~~.

(b) The consent described in subsection (a) must be either of the following:

(1) in a record signed before, on, or after the birth of the child by the woman or individual who gave birth to the child and by an individual who intends to be a parent of the child; an acknowledgment of parentage under Section 301 is a record within the meaning of this subsection; or

(2) in an agreement entered into before conception that the woman or individual who gave birth to the child and the individual who intends to be a parent of the child intended they both would be a parent of the child.

Failure to consent as required by paragraph (1) or (2) of subsection (b) does not preclude a court from finding consent to parent if the individual for the first 2 years of the child's life, including any period of temporary absence, resided in the same household with the child and openly held out the child as the individual's child ~~If a person makes an anonymous gamete donation without a designated intended parent at the time of the gamete donation, the intended parent is the parent of any resulting child if the anonymous donor relinquished his or her parental rights in writing at the time of donation. The written relinquishment shall be directed to the entity to which the donor donated his or her gametes~~.

(c) An individual who is an intended parent or the woman or individual who gave birth to the child may bring a proceeding for a judgment of parentage before or after the birth of the child. If the court finds that the individual who did not give birth consented under subsection (b) of this Section, the court shall enter a judgment of parentage declaring the individual to be the parent ~~seek a court order confirming the existence of a parent-child relationship prior to or after the birth of a child based on compliance with subsection (a) or (b) of this Section~~.

(d) The woman or individual who will give or who gave birth to the child or an individual who is or claims to be a parent under this Section may commence an action before or after the birth of a child to obtain a judgment to declare that the intended parent or parents are the parent or parents of the resulting child immediately on birth of the child and order that parental rights and responsibilities vest exclusively in the intended parent or parents immediately on birth of the child. A judgment issued before the birth of the resulting child takes effect on the birth of the resulting child. The State, the Department, and the hospital where the child is or is expected to be born are not necessary parties to an action under this Section ~~If the requirements of subsection (a) of this Section are not met, or subsection (b) of this Section is found by a court to be inapplicable, a court of competent jurisdiction shall determine parentage based on evidence of the parties' intent at the time of donation~~.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 46/704)

Sec. 704. Withdrawal of consent of intended parent ~~or donor~~.

(a) An intended parent ~~or donor~~ may withdraw consent to assisted reproduction any time before an insemination or a transfer that results in a pregnancy ~~to use his or her gametes~~ in a writing or legal pleading with notice to the other participants and to any clinic or health care providers facilitating the assisted reproduction. Failure to give notice to the clinic or health care provider does not affect a determination of parentage under this Act.

(b) An intended parent who withdraws consent under this Section prior to the insemination or embryo transfer is not a parent of any resulting child. ~~If a donor withdraws consent to his or her donation prior to the insemination or the combination of gametes, the intended parent is not the parent of any resulting child.~~

~~If the intended parent or parents no longer wish to use any remaining cryopreserved fertilized ovum for medical purposes, the terms of the most recent informed consent of the intended parent or parents executed at the fertility center or a marital settlement agreement under a judgment of dissolution of marriage, judgment of legal separation, or judgment of dissolution of civil union governs the disposition of the fertilized ovum.~~

(Source: P.A. 102-1117, eff. 1-13-23.)

(750 ILCS 46/704.5 new)

Sec. 704.5. Disposition.

(a) An intended parent may withdraw consent to use the parent's gametes in a writing or legal pleading with notice to the other participant, or clinic, if applicable, or gamete bank, if applicable, prior to insemination or in vitro fertilization.

(b) If the intended parent or parents no longer agree on the use of any cryopreserved fertilized ovum for medical purposes, the terms of the most recent informed consent of the intended parent or parents executed at the fertility center or a marital settlement agreement under a judgment of dissolution of marriage, judgment of legal separation, or judgment of dissolution of civil union governs the disposition of the cryopreserved fertilized ovum.

(750 ILCS 46/705)

Sec. 705. Parental status of deceased individual.

(a) If an individual who intends to be a parent of a child conceived by assisted reproduction dies during the period between the transfer of a gamete or embryo and the birth of the child, the individual's death does not preclude the establishment of the individual's parentage of the child if the individual otherwise would be a parent of the child under this Act.

(b) If an individual who consented in a record to assisted reproduction by an individual who agreed to give birth to a child dies before a transfer of gametes or pre-embryos, the deceased individual is a parent of a child conceived by the assisted reproduction only if both of the following occurred: (i) Either the individual consented in a record that if assisted reproduction were to occur after the death of the individual, the individual would be a parent of the child or the individual's intent to be a parent of a child conceived by assisted reproduction after the individual's death is established by clear and convincing evidence; and (ii) the transfer of the gamete or pre-embryo transfer occurs not later than 36 months after the individual's death ~~If an individual consents in a writing to be a parent of any child born of his or her gametes posthumously, and dies before the insemination of the individual's gametes or embryo transfer, the deceased individual is a parent of any resulting child born within 36 months of the death of the deceased individual~~.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 46/707)

Sec. 707. Burden of proof. Unless otherwise specified in this Act, the burden of proof in an action under this Section is by a preponderance of the evidence ~~Parentage established under Section 703, a withdrawal of consent under Section 704, or a proceeding to declare the non-existence of the parent-child relationship under Section 708 of this Act must be proven by clear and convincing evidence~~.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 46/708)

Sec. 708. Limitation on proceedings to declare the non-existence of the parent-child relationship. An individual who, at the time of a child's birth, is the spouse of the woman or person who gave birth cannot bring an action to declare the non-existence of the parent-child relationship under this Article unless filed and served not later than 2 years from the child's date of birth ~~shall be barred if brought more than 2 years following the birth of the child~~.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 46/709)

Sec. 709. Establishment of parentage; requirements of Gestational Surrogacy Act.

(a) In the event of gestational surrogacy, in addition to the requirements of the Gestational Surrogacy Act, a parent-child relationship is established between a person and a child if all of the following conditions are met prior to the birth of the child:

(1) The gestational surrogate certifies that the surrogate ~~she~~ did not provide a gamete for the child, and that the surrogate ~~she~~ is carrying the resulting child for the intended parents.

(2) The spouse, if any, of the gestational surrogate certifies that the spouse ~~he or she~~ did not provide a gamete for the child.

(3) (Blank). ~~Each intended parent, or the parent's legally authorized designee if an intended parent dies, certifies that the child being carried by the gestational surrogate was conceived using at least one of the intended parents' gametes.~~

(4) A physician licensed in the location ~~state~~ in which the fertilized ovum was inseminated or transferred to the gestational surrogate or the licensed physician treating the gestational surrogate certifies that the fetus ~~child~~ being carried by the gestational surrogate was not conceived with the gamete of the ~~using the gamete or gametes of at least one of the intended parents, and that neither the gestational surrogate nor the gestational surrogate's spouse, if any, provided gametes for the child being carried by the~~ gestational surrogate and the intended parents meet the eligibility requirements as set forth in the Gestational Surrogacy Act.

(5) The attorneys for the intended parents and the gestational surrogate each certify that the parties who entered into a gestational surrogacy agreement complied with ~~intended to satisfy~~ the requirements of the Gestational Surrogacy Act.

(b) All certifications under this Section shall be in writing and witnessed by 2 competent adults who are not the gestational surrogate, gestational surrogate's spouse, if any, or an intended parent. Certifications shall be on forms prescribed by the Illinois Department of Public Health and shall be executed prior to the birth of the child. All certifications shall be provided, prior to the birth of the child, to both the hospital where the gestational surrogate anticipates the delivery will occur and to the Illinois Department of Public Health. Certifications may be provided electronically.

(c) Parentage established in accordance with this Section has the full force and effect of a judgment entered under this Act.

(d) The Illinois Department of Public Health shall adopt rules to implement this Section.

(Source: P.A. 102-1117, eff. 1-13-23.)

(750 ILCS 46/710)

Sec. 710. Applicability. This Article applies only to assisted reproductive arrangements or gestational surrogacy agreements ~~contracts~~ entered into after the effective date of this amendatory Act of the 99th General Assembly.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 46/903)

Sec. 903. Transitional provision. A proceeding to adjudicate parentage which was commenced before the effective date of this Act is governed by the law in effect at the time the proceeding was commenced, except that this Act applies to all pending actions and proceedings commenced before January 1, 2016 with respect to issues on which a judgment has not been entered. A proceeding to adjudicate parentage that was commenced before the effective date of this amendatory Act of the 104th General Assembly is governed by the law in effect at the time the proceeding was commenced.

(Source: P.A. 99-85, eff. 1-1-16; 99-769, eff. 1-1-17.)

Section 10. The Gestational Surrogacy Act is amended by changing Sections 5, 10, 15, 20, 25, 30, 35, 55, 60, 70, and 75 and by adding Sections 26, 27, 36, 37, and 39 as follows:

(750 ILCS 47/5)

Sec. 5. Purpose. The purpose of this Act is to establish consistent standards and procedural safeguards for the protection of all parties involved in a gestational surrogacy agreement ~~contract~~ in this State and to confirm the legal status of children born as a result of these agreements ~~contracts~~. These standards and safeguards are meant to facilitate the use of this type of reproductive contract in accord with the public policy of this State.

(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/10)

Sec. 10. Definitions. As used in this Act:

"Compensation" means payment of any valuable consideration for services in excess of reasonable medical and ancillary costs.

"Donor" means a person who provides gametes intended for use in assisted reproduction, whether or not for compensation. "Donor" does not include a person who is a parent under Article 7 of the Illinois Parentage Act of 2015 or an intended parent under this Act ~~an individual who contributes a gamete or gametes for the purpose of in vitro fertilization or implantation in another~~.

"Gamete" means either a sperm or an egg.

"Gestational surrogacy" means the process by which a woman or person ~~woman~~ attempts to become pregnant ~~carry~~ and give birth to a child conceived ~~created~~ through in vitro fertilization ~~using the gamete or gametes of at least one of the intended parents~~ and to which the gestational surrogate has made no genetic contribution.

"Gestational surrogate" means a woman or person ~~woman~~ who agrees to engage in a gestational surrogacy.

"Gestational surrogacy agreement ~~contract~~" means a written agreement regarding gestational surrogacy.

"Health care provider" means a person who is duly licensed to provide health care, including all medical, psychological, or counseling professionals.

"Intended parent" means a person ~~person or persons~~ who consents to assisted reproduction, including ~~enters into~~ a gestational surrogacy agreement, such that the person is a legal ~~contract with a gestational surrogate pursuant to which he or she will be the legal~~ parent of the resulting child. "Intended ~~In the case of a married couple, any reference to an intended~~ parent" includes, in the case of a married couple, ~~shall include~~ both spouses ~~husband and wife~~ for all purposes of this Act. ~~This term shall include the intended mother, intended father, or both.~~

"In vitro fertilization" means all medical and laboratory procedures that are necessary to effectuate the extracorporeal fertilization of egg and sperm.

"Medical evaluation" means an evaluation and consultation of a physician meeting the requirements of Section 60.

"Mental health evaluation" means an evaluation and consultation of a mental health professional meeting the requirements of Section 60.

"Physician" means a person licensed to practice medicine in all its branches in the state in which they practice ~~Illinois~~.

"Pre-embryo" means a fertilized egg prior to 14 days of development.

"Pre-embryo transfer" means all medical and laboratory procedures that are necessary to effectuate the transfer of a pre-embryo into the uterine cavity.

(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/15)

Sec. 15. Rights of Parentage.

(a) Except as provided in this Act, the woman or person ~~woman~~ who gives birth to a child is a parent ~~presumed to be the mother~~ of that child for purposes of State law.

(b) In the case of a gestational surrogacy agreement that substantially complies with ~~satisfying~~ the requirements set forth in Sections 20 and 25 of this Act ~~subsection (d) of this Section~~:

(1) the intended parent or parents ~~mother~~ shall be considered the parent or parents ~~mother~~ of the child for all purposes ~~of State law~~ immediately upon the birth of the child;

~~(2) the intended father shall be the father of the child for purposes of State law immediately upon the birth of the child;~~

~~(3) the child shall be considered the legitimate child of the intended parent or parents for purposes of State law immediately upon the birth of the child;~~

~~(4) parental rights shall vest in the intended parent or parents immediately upon the birth of the child;~~

~~(5) sole custody of the child shall rest with the intended parent or parents immediately upon the birth of the child; and~~

(2) ~~(6)~~ neither the gestational surrogate nor the surrogate's spouse ~~her husband~~, if any, shall be considered the parents of the child for purposes of State law immediately upon the birth of the child.

(c) In the case of a gestational surrogacy agreement meeting the requirements set forth in subsection (d) of this Section, in the event of a laboratory error in which the resulting child is not genetically related to

either of the intended parents or a donor who donated to the intended parent or parents, the intended parents will be the parents of the child for all purposes ~~of State law~~ unless otherwise determined by a court of competent jurisdiction.

(d) (Blank). ~~The parties to a gestational surrogacy shall assume the rights and obligations of subsections (b) and (c) of this Section if:~~

~~(1) the gestational surrogate satisfies the eligibility requirements set forth in subsection (a) of Section 20;~~

~~(2) the intended parent or parents satisfy the eligibility requirements set forth in subsection (b) of Section 20; and~~

~~(3) the gestational surrogacy occurs pursuant to a gestational surrogacy contract meeting the requirements set forth in Section 25.~~

(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/20)

Sec. 20. Eligibility.

(a) A gestational surrogate shall be deemed to have satisfied the eligibility requirements of this Act if, ~~she has met the following requirements~~ at the time the gestational surrogacy agreement ~~contract~~ is executed, the gestational surrogate:

(1) ~~she~~ is at least 21 years of age;

(2) ~~she~~ has given birth to at least one child;

(3) ~~she~~ has completed a medical evaluation;

(4) ~~she~~ has completed a mental health evaluation;

(5) ~~she~~ has had and will have ongoing legal representation by independent counsel, licensed in Illinois and chosen by the surrogate, throughout the course of the gestational surrogacy arrangement regarding the terms ~~undergone legal consultation with independent legal counsel regarding the terms of the gestational surrogacy contract and the potential legal consequences~~ of the gestational surrogacy agreement and the potential consequences of the gestational surrogacy; and

(6) ~~she~~ has obtained a health insurance policy that covers major medical treatments and hospitalization and the health insurance policy has a term that extends throughout the duration of the expected pregnancy and for 8 weeks after the birth of the child; provided, however, that the policy may be procured by the intended parents on behalf of the gestational surrogate pursuant to the gestational surrogacy agreement ~~contract~~.

(b) The intended parent or parents shall be deemed to have satisfied the eligibility requirements of this Act if, ~~he, she, or they have met the following requirements~~ at the time the gestational surrogacy agreement ~~contract~~ is executed, the intended parent or parents:

(1) is at least 21 years of age ~~he, she, or they contribute at least one of the gametes resulting in a pre-embryo that the gestational surrogate will attempt to carry to term~~;

(2) are experiencing infertility as defined in subsection (c) of Section 356m of the Illinois Insurance Code ~~he, she, or they have a medical need for the gestational surrogacy as evidenced by a qualified physician's affidavit attached to the gestational surrogacy contract and as required by the Illinois Parentage Act of 2015~~;

(3) ~~he, she, or they~~ have completed a mental health evaluation; and

(4) has had and will have ongoing ~~he, she, or they have undergone~~ legal representation by ~~consultation with~~ independent ~~legal~~ counsel, licensed in Illinois, throughout the course of the gestational surrogacy arrangement regarding the terms of the gestational surrogacy agreement ~~contract~~ and the potential legal consequences of the gestational surrogacy.

(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 47/25)

Sec. 25. Requirements for a gestational surrogacy agreement ~~contract~~.

(a) (Blank). ~~A gestational surrogacy contract shall be presumed enforceable for purposes of State law only if:~~

~~(1) it meets the contractual requirements set forth in subsection (b) of this Section; and~~

~~(2) it contains at a minimum each of the terms set forth in subsection (c) of this Section.~~

(b) A gestational surrogacy agreement ~~contract~~ shall meet the following requirements:

(1) it shall be in writing;

(2) it shall be executed prior to the commencement of any medical procedures (other than medical or mental health evaluations necessary to determine eligibility of the parties pursuant to Section 20 of this Act) in furtherance of the gestational surrogacy:

(i) by a gestational surrogate meeting the eligibility requirements of subsection (a) of Section 20 of this Act and, if married, the gestational surrogate's spouse ~~husband~~; and

(ii) by the intended parent or parents meeting the eligibility requirements of subsection (b) of Section 20 of this Act. In the event an intended parent is married, both the intended parent and spouse ~~husband and wife~~ must execute the gestational surrogacy agreement ~~contract~~;

(3) each of the gestational surrogate and the intended parent or parents shall have been represented by independent legal counsel licensed in Illinois regarding the terms of the gestational surrogacy agreement and the potential legal consequences of the gestational surrogacy ~~separate counsel in all matters concerning the gestational surrogacy and the gestational surrogacy contract~~;

(3.5) it shall indicate ~~each of the gestational surrogate and the intended parent or parents shall have signed a written acknowledgement~~ that each party has ~~he or she~~ received information about the legal, financial, and contractual rights, expectations, penalties, and obligations of the surrogacy agreement;

(4) it shall require the intended parent or parents to pay for independent legal representation for the surrogate;

(5) if the gestational surrogacy agreement ~~contract~~ provides for the payment of compensation to the gestational surrogate, the compensation shall have been placed in escrow with an ~~independent~~ escrow agent that is independent of and is not affiliated with either the intended parents' attorney or the gestational surrogate's attorney prior to the gestational surrogate's commencement of any medical procedure (other than medical or mental health evaluations necessary to determine the gestational surrogate's eligibility pursuant to subsection (a) of Section 20 of this Act); and

(6) ~~(5)~~ it shall be witnessed by 2 competent adults or shall be notarized consistent with Illinois law.

(b-5) A gestational surrogacy agreement may provide for the payment of compensation and reasonable expenses.

(c) A gestational surrogacy agreement ~~contract~~ shall provide for:

(1) the express written agreement of the gestational surrogate to:

(i) undergo pre-embryo transfer and attempt to become pregnant ~~carry~~ and give birth to the child; and

(ii) surrender custody of the child to the intended parent or parents immediately upon the birth of the child;

(2) if the gestational surrogate is married, the express agreement of the gestational surrogate's spouse ~~her husband~~ to:

(i) undertake the obligations imposed on the gestational surrogate pursuant to the terms of the gestational surrogacy agreement ~~contract~~;

(ii) surrender custody of the child to the intended parent or parents immediately upon the birth of the child;

(3) the right of the gestational surrogate to utilize the services of a physician of the gestational surrogate's ~~her~~ choosing~~, after consultation with the intended parents,~~ to provide the gestational surrogate with ~~her~~ care during the pregnancy; ~~and~~

(4) the express written agreement of the intended parent or parents to:

(i) accept custody of the child immediately upon the child's ~~his or her~~ birth; and

(ii) assume sole responsibility for the support of the child immediately upon the child's ~~his or her~~ birth;~~.~~

(iii) make all health and welfare decisions regarding the surrogate and the pregnancy, except that this Act does not enlarge or diminish the surrogate's right to terminate their pregnancy, and any written or oral agreement purporting to waive or limit these rights shall be void as against public policy;

(iv) disclose all of intended parent's financial obligations with regard to the gestational surrogate, including compensation and expenses; and

(v) include information about each party's right under this Act to terminate the surrogacy agreement.

(d) (Blank). ~~A gestational surrogacy contract shall be presumed enforceable for purposes of State law even though it contains one or more of the following provisions:~~

~~(1) the gestational surrogate's agreement to undergo all medical exams, treatments, and fetal monitoring procedures that the physician recommended for the success of the pregnancy;~~

~~(2) the gestational surrogate's agreement to abstain from any activities that the intended parent or parents or the physician reasonably believes to be harmful to the pregnancy and future health of the child, including, without limitation, smoking, drinking alcohol, using nonprescribed drugs, using prescription drugs not authorized by a physician aware of the gestational surrogate's pregnancy, exposure to radiation, or any other activities proscribed by a health care provider;~~

~~(3) the agreement of the intended parent or parents to pay the gestational surrogate reasonable compensation; and~~

~~(4) the agreement of the intended parent or parents to pay for or reimburse the gestational surrogate for reasonable expenses (including, without limitation, medical, legal, or other professional expenses) related to the gestational surrogacy and the gestational surrogacy contract.~~

(e) (Blank). ~~In the event that any of the requirements of this Section are not met, a court of competent jurisdiction shall determine parentage based on evidence of the parties' intent.~~

(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/26 new)

Sec. 26. Effect of subsequent change of marital status.

(a) Unless a gestational surrogacy agreement expressly provides otherwise, both of the following apply:

(1) The marriage of a surrogate after the surrogacy agreement is signed by all parties does not affect the validity of the agreement, the spouse's consent to the agreement is not required, and the spouse is not a presumed parent of a child conceived by assisted reproduction under the agreement.

(2) The dissolution, annulment, or declaration of invalidity of the surrogate's marriage, the legal separation of the surrogate, or a judgment of separate maintenance concerning the surrogate after the surrogacy contract is signed by all parties does not affect the validity of the agreement.

(3) Unless a surrogacy agreement expressly provides otherwise, both of the following apply:

(A) The marriage of an intended parent after the surrogacy agreement is signed by all parties does not affect the validity of a surrogacy agreement, the consent of the spouse is not required, and the spouse is not, based on the agreement, a parent of a child conceived by assisted reproduction under the agreement.

(B) The dissolution, annulment, or declaration of invalidity of an intended parent's marriage, the legal separation of an intended parent, or a judgment of separate maintenance concerning an intended parent after the agreement is signed by all parties does not affect the validity of the agreement and, except as otherwise provided in Section 36, the intended parent is a parent of the child.

(750 ILCS 47/27 new)

Sec. 27. Termination.

(a) A party to a gestational surrogacy agreement may terminate the agreement at any time before an embryo transfer by giving notice of termination in a record to all other parties. If an embryo transfer does not result in a pregnancy, a party may terminate the agreement at any time before a subsequent embryo transfer.

(b) Unless a gestational surrogacy agreement provides otherwise, on termination of the agreement under subsection (a), the parties are released from the agreement, except that each intended parent remains responsible for expenses that are contemplated under the agreement and incurred by the gestational surrogate through the date of termination of the surrogacy agreement or as otherwise agreed to in the gestational surrogacy agreement.

(c) Unless there is fraud, a party is not liable to any other party for a penalty or liquidated damages for terminating a gestational surrogacy agreement under this Section.

(750 ILCS 47/30)

Sec. 30. Duty to support.

(a) Any person who is a ~~considered to be the~~ parent of a child pursuant to ~~Section 15 of~~ this Act shall be obligated to support the child.

(b) The breach of the gestational surrogacy agreement ~~contract~~ by the intended parent or parents shall not relieve such intended parent or parents of the support obligations imposed by this Act.

(c) ~~A gamete donor may be liable for child support only if he or she fails to enter into a legal agreement with the intended parent or parents in which the intended parent or parents agree to assume all rights and responsibilities for any resulting child, and the gamete donor relinquishes his or her rights to any gametes, resulting embryos, or children.~~

(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/35)

Sec. 35. Establishment of parentage ~~the parent-child relationship~~.

(a) In the event of gestational surrogacy, in addition to the requirements of the Articles 2 and 3 of the Illinois Parentage Act of 2015, a parent-child relationship is established by operation of law, upon birth of the child, between a person and a child if all of the following conditions are met:

(1) Each intended parent certifies compliance with the eligibility requirements of Section 20.

(2) The gestational surrogate certifies compliance with the eligibility requirements of Section 20 and did not provide a gamete for the child, and that the gestational surrogate is carrying the resulting child for the intended parents.

(3) A physician licensed in the state in which the pre-embryo was transferred to the gestational surrogate certifies that the pre-embryo that was transferred to the gestational surrogate was not formed with the gamete of the gestational surrogate.

(4) The attorneys for the intended parent or parents and the gestational surrogate and spouse, if any, each certify that the parties substantially satisfied the requirements of Section 25 of this Act ~~For purposes of the Illinois Parentage Act of 2015, a parent-child relationship shall be established prior to the birth of a child born through gestational surrogacy if, in addition to satisfying the requirements of Articles 2 and 3 of the Illinois Parentage Act of 2015, the attorneys representing both the gestational surrogate and the intended parent or parents certify that the parties entered into a gestational surrogacy contract intended to satisfy the requirements of Section 25 of this Act with respect to the child~~.

(b) All certifications under this Section shall be in writing and witnessed by 2 competent adults who are not the gestational surrogate, gestational surrogate's spouse, if any, or an intended parent. Certifications shall be on forms prescribed by the Illinois Department of Public Health and shall be executed before the birth of the child. All certifications shall be provided, before the birth of the child, to both the hospital where the gestational surrogate anticipates the delivery will occur and to the Illinois Department of Public Health ~~The attorneys' certifications required by subsection (a) of this Section shall be filed on forms prescribed by the Illinois Department of Public Health and in a manner consistent with the requirement of the Illinois Parentage Act of 2015~~.

(c) Parentage established in accordance with this Section has the full force and effect of a judgment entered under this Act.

(d) The Illinois Department of Public Health shall adopt rules to implement this Section.

(Source: P.A. 99-85, eff. 1-1-16.)

(750 ILCS 47/36 new)

Sec. 36. Establishment of parentage with a substantially compliant agreement.

(a) A gestational surrogacy agreement that substantially complies with this Act is enforceable.

(b)(1) Before, on, or after the birth of a child conceived by assisted reproduction under a gestational surrogacy agreement substantially compliant with this Act, a party to the agreement may commence an action in the circuit court for entry of a parentage judgment. The requested parentage judgment may be issued before or after the child's birth as requested by the parties. Either the gestational surrogate or the intended parent may bring the action. If the action is brought prior to all certifications required by Section 35 being filed, all parties must receive notice of such action.

(2) A petition shall include: (A) a copy of the executed gestational surrogacy agreement; (B) the certification of the assisted reproduction physician under Section 35; and (C) certifications from the attorneys representing the intended parent or parents and the gestational surrogate and spouse (if any) under Section 35. A petition supported by such certifications shall be sufficient to establish parentage and a hearing shall not be required unless the court requires additional information which cannot reasonably be ascertained without a hearing.

(3) Upon a finding by a preponderance of the evidence that the petition satisfies paragraph (2) of subsection (b), a court shall no later than 30 days from the filing of the petition, issue a judgment of parentage.

(4) The court shall issue a judgment:

(A) declaring that each intended parent is a parent of the child and ordering that parental rights and duties vest immediately upon the birth of the child exclusively in each intended parent;

(B) declaring that the gestational surrogate and the surrogate's spouse or former spouse, if any, are not the parents of the child;

(C) if necessary, ordering that the hospital where the child will be or has been born, treat the intended parent or parents as the sole legal parent or parents for all purposes;

(D) designating the content of the birth record and directing the Department of Public Health to designate each intended parent as a parent of the child, if such record has not yet been established or needs to be amended;

(E) if necessary, ordering that the child be surrendered to the intended parent or parents; and

(F) for other relief the court determines proper.

(5) To protect the privacy of the child and the parties, all records related to such action shall be impounded.

(6) The Department of Public Health, the town or city clerk, and the hospital where the child is born or is intended to be born shall not be necessary parties to a proceeding.

(7) Parentage judgments issued under this Section shall conclusively establish the parent-child relationship for all purposes.

(750 ILCS 47/37 new)

Sec. 37. Parentage and substantial noncompliance.

(a) If a gestational surrogacy agreement does not substantially comply with the requirements of this Act:

(1) The court shall determine the rights and duties of the parties to the agreement consistent with the intent of the parties at the time of execution, taking into account the best interests of the child.

(2) Each party to the surrogacy agreement and any individual who at the time of the execution of the agreement was a spouse of a party to the agreement has standing to maintain an action to adjudicate an issue related to the enforcement of the agreement. Any party to the agreement not joining in the action shall be provided with notice of the proceeding.

(750 ILCS 47/39 new)

Sec. 39. Jurisdiction and venue. Any judicial proceeding under the Gestational Surrogacy Act is subject to the jurisdiction and venue provisions set forth in Sections 603 and 604 of the Illinois Parentage Act of 2015.

(750 ILCS 47/55)

Sec. 55. Damages.

(a) Except as expressly provided in the gestational surrogacy agreement or in subsection (b), if the agreement is breached by the gestational surrogate or one or more intended parents, the non-breaching party is entitled to the remedies available at law or in equity ~~contract, the intended parent or parents shall be entitled to all remedies available at law or equity~~.

(b) The breach of the gestational surrogacy agreement by one or more intended parents does not relieve the intended parent of the support obligations imposed by the parent and child relationship under this Act ~~Except as expressly provided in the gestational surrogacy contract, the gestational surrogate shall be entitled to all remedies available at law or equity~~.

(c) Specific performance is not a remedy available for breach by a gestational surrogate of provision in the agreement that the gestational surrogate be impregnated, terminate a pregnancy, or submit to medical procedures.

(d) Except as otherwise provided in subsection (c), if an intended parent is determined to be a parent of the child, specific performance is a remedy available for either of the following:

(1) Breach of the gestational surrogacy agreement by a gestational surrogate that prevents an intended parent from exercising the full rights of parentage immediately upon birth of the child.

(2) Breach of the gestational surrogacy agreement by an intended parent that prevents the intended parent's acceptance of the duties of parentage immediately upon birth of the child.

(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/60)

Sec. 60. Rulemaking. The Department of Public Health may adopt rules pertaining to the required medical and mental health evaluations for a gestational surrogacy agreement ~~contract~~. Until the Department of Public Health adopts such rules, medical and mental health evaluations and procedures shall be

conducted in accordance with the recommended guidelines published by the American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists. The rules may adopt these guidelines or others by reference.
(Source: P.A. 93-921, eff. 1-1-05.)

(750 ILCS 47/70)

Sec. 70. Irrevocability. No action to invalidate a gestational surrogacy meeting the requirements of subsection (d) of Section 20 and Section 25 ~~15~~ of this Act or to challenge the rights of parentage established pursuant to the Gestational Surrogacy Act ~~Section 15 of this Act and the Illinois Parentage Act of 2015~~ shall be commenced after 12 months from the date of birth of the child.
(Source: P.A. 99-763, eff. 1-1-17.)

(750 ILCS 47/75)

Sec. 75. Application. The provisions of this Act shall apply only to gestational surrogacy agreements ~~contracts~~ entered into after the effective date of this Act.
(Source: P.A. 93-921, eff. 1-1-05.)

Section 15. The Adoption Act is amended by adding Section 21.1 as follows:

(750 ILCS 50/21.1 new)

Sec. 21.1. Confirmatory adoption for children born through assisted reproduction.

(a) As used in this Section, the following words and terms shall have the following meanings unless the context shall clearly indicate another or different meaning or intent:

"Assisted reproduction" means the definition provided in the Illinois Parentage Act of 2015.

"Marriage" means and includes civil union and any legal relationship that provides substantially the same rights, benefits, and responsibilities as marriage and is recognized as valid in the state or jurisdiction in which it was entered.

"Petitioner" means the person filing a petition for adoption in accordance with this Section.

(b) A petition for adoption may be filed in accordance with this Section if a child is born (1) as a result of assisted reproduction involving a donor in compliance with Article 7; or (2) as a result of an arrangement in substantial compliance with the Gestational Surrogacy Act and the pleadings provide relevant documentation regarding compliance or substantial compliance.

(c) The court may proceed in accordance with this Section under other circumstances not outlined in subsection (b) in its discretion.

(d) A complete petition shall be comprised of the following:

(1) the petition for adoption signed by each petitioner;

(2) a copy of the petitioners' marriage certificate, if petitioners are married;

(3) a declaration by the petitioners explaining the circumstances of the child's birth through assisted reproduction, attesting to their consent to assisted reproduction, and medical or other documentation relating to the assisted reproduction regarding procurement of donor gamete(s) or medical procedures resulting in the pregnancy and birth of the child; and

(4) a copy of the child's birth certificate.

(e) A complete petition for adoption, as described in subsection (c) of this Section, shall serve as the petitioners' written consents to adoption, and no additional consent or notice shall be required. The petition shall be verified by the petitioners.

(f) If the petitioners conceived through assisted reproduction with donor gamete or donor embryo under Article 7 of the Illinois Parentage Act of 2015, the court shall not require notice of the adoption to the donor.

(g) Unless otherwise ordered by the court for good cause shown and supported by written findings, for purposes of evaluating and granting a petition for adoption under this Section, the court may not require any of the following:

(1) an in-person hearing or appearance;

(2) an investigation or home study by, notice to, or approval of the Department of Children and Family Services;

(3) appointment of a guardian ad litem;

(4) a criminal background check; or

(5) a minimum residency period in the home of the petitioners.

(h) The court shall grant the adoption under this Section and issue a decree of adoption within 30 days or as soon as is possible after the petition has been filed if it finds:

(1) the child was born through assisted reproduction;

(2) each intended parent consented to the assisted reproduction as evidenced by the parent's signature to the petition; and

(3) there are no competing claims of parentage.

(i) A petition to adopt pursuant to this Section, when a petitioner's parentage is presumed or legally recognized under Illinois law, must not be denied on the basis that the petitioner's parentage is already presumed or legally recognized.

(j) Effect on other laws. When parentage is presumed or legally recognized under Illinois law, it may not be considered as evidence of parentage or evidence of the best interests of the child in any manner that the parties did not petition for adoption under this Section.

(k) For purposes of a confirmatory adoption, jurisdiction and venue is governed by Section 603 of the Illinois Parentage Act of 2015 or the Adoption Act.

(l) The confidentiality provisions in Section 18 apply to this Section.

Section 99. Effective date. This Act takes effect upon becoming law, except that the changes to Sections 301, 302, 303, and 305 of the Illinois Parentage Act of 2015 take effect on 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.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Harmon, **House Bill No. 2568** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 36; NAYS 19.

The following voted in the affirmative:

Aquino	Glowiak Hilton	Koehler	Ventura
Castro	Guzmán	Martwick	Villa
Cervantes	Halpin	Morrison	Villanueva
Collins	Harris, N.	Murphy	Villivalam
Cunningham	Hastings	Peters	Walker
Edly-Allen	Holmes	Porfirio	Mr. President
Ellman	Hunter	Preston	
Faraci	Johnson	Simmons	
Feigenholtz	Jones, E.	Sims	
Fine	Joyce	Stadelman	

The following voted in the negative:

Anderson	Curran	Lewis	Syverson
Arellano, L.	DeWitte	McClure	Tracy
Balkema	Fowler	Plummer	Turner, S.
Bryant	Harriss, E.	Rezin	Wilcox
Chesney	Hills	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 in the Senate Amendments adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Martwick, **House Bill No. 3193** was recalled from the order of third reading to the order of second reading.

Senator Martwick offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 3193

AMENDMENT NO. 2. Amend House Bill 3193, AS AMENDED, by replacing everything after the enacting clause with the following:

"Article 1.

Section 1-5. The Illinois Pension Code is amended by changing Section 17-149 as follows:

(40 ILCS 5/17-149) (from Ch. 108 1/2, par. 17-149)

Sec. 17-149. Cancellation of pensions.

(a) If any person receiving a disability retirement pension from the Fund is re-employed as a teacher by an Employer, the pension shall be cancelled on the date the re-employment begins, or on the first day of a payroll period for which service credit was validated, whichever is earlier.

(b) If any person receiving a service retirement pension from the Fund is re-employed as a teacher on a permanent or annual basis by an Employer, the pension shall be cancelled on the date the re-employment begins, or on the first day of a payroll period for which service credit was validated, whichever is earlier. However, subject to the limitations and requirements of subsection (c-5), (c-6), (c-7), or (c-10), the pension shall not be cancelled in the case of a service retirement pensioner who is re-employed on a temporary and non-annual basis or on an hourly basis.

(c) If the date of re-employment on a permanent or annual basis occurs within 5 school months after the date of previous retirement, exclusive of any vacation period, the member shall be deemed to have been out of service only temporarily and not permanently retired. Such person shall be entitled to pension payments for the time he could have been employed as a teacher and received salary, but shall not be entitled to pension for or during the summer vacation prior to his return to service.

When the member again retires on pension, the time of service and the money contributed by him during re-employment shall be added to the time and money previously credited. Such person must acquire 3 consecutive years of additional contributing service before he may retire again on a pension at a rate and under conditions other than those in force or attained at the time of his previous retirement.

(c-5) For school years beginning on or after July 1, 2019 and before July 1, 2022, the service retirement pension shall not be cancelled in the case of a service retirement pensioner who is re-employed as a teacher on a temporary and non-annual basis or on an hourly basis, so long as the person (1) does not work as a teacher for compensation on more than 120 days in a school year or (2) does not accept gross compensation for the re-employment in a school year in excess of (i) $30,000 or (ii) in the case of a person who retires with at least 5 years of service as a principal, an amount that is equal to the daily rate normally paid to retired principals multiplied by 100. These limitations apply only to school years that begin on or after July 1, 2019 and before July 1, 2022. Such re-employment does not require contributions, result in service credit, or constitute active membership in the Fund.

The service retirement pension shall not be cancelled in the case of a service retirement pensioner who is re-employed as a teacher on a temporary and non-annual basis or on an hourly basis, so long as the person (1) does not work as a teacher for compensation on more than 100 days in a school year or (2) does not accept gross compensation for the re-employment in a school year in excess of (i) $30,000 or (ii) in the case of a person who retires with at least 5 years of service as a principal, an amount that is equal to the daily rate normally paid to retired principals multiplied by 100. These limitations apply only to school years that begin on or after August 8, 2012 (the effective date of Public Act 97-912) and before July 1, 2019. Such re-employment does not require contributions, result in service credit, or constitute active membership in the Fund.

Notwithstanding the 120-day limit set forth in item (1) of this subsection (c-5), the service retirement pension shall not be cancelled in the case of a service retirement pensioner who teaches only driver education courses after regular school hours and does not teach any other subject area, so long as the person does not work as a teacher for compensation for more than 900 hours in a school year. The $30,000 limit set

forth in subitem (i) of item (2) of this subsection (c-5) shall apply to a service retirement pensioner who teaches only driver education courses after regular school hours and does not teach any other subject area.

To be eligible for such re-employment without cancellation of pension, the pensioner must notify the Fund and the Board of Education of his or her intention to accept re-employment under this subsection (c-5) before beginning that re-employment (or if the re-employment began before August 8, 2012 (the effective date of Public Act 97-912), then within 30 days after that effective date).

An Employer must certify to the Fund the temporary and non-annual or hourly status and the compensation of each pensioner re-employed under this subsection at least quarterly, and when the pensioner is approaching the earnings limitation under this subsection.

If the pensioner works more than 100 days or accepts excess gross compensation for such re-employment in any school year that begins on or after August 8, 2012 (the effective date of Public Act 97-912), the service retirement pension shall thereupon be cancelled.

If the pensioner who only teaches drivers education courses after regular school hours works more than 900 hours or accepts excess gross compensation for such re-employment in any school year that begins on or after August 12, 2016 (the effective date of Public Act 99-786), the service retirement pension shall thereupon be cancelled.

If the pensioner works more than 120 days or accepts excess gross compensation for such re-employment in any school year that begins on or after July 1, 2019, the service retirement pension shall thereupon be cancelled.

The Board of the Fund shall adopt rules for the implementation and administration of this subsection.

(c-6) For school years beginning on or after July 1, 2022 and before July 1, 2027, the service retirement pension shall not be cancelled in the case of a service retirement pensioner who is re-employed as a teacher or an administrator on a temporary and non-annual basis or on an hourly basis, so long as the person does not work as a teacher or an administrator for compensation on more than 140 days in a school year. Such re-employment does not require contributions, result in service credit, or constitute active membership in the Fund.

(c-7) For school years beginning on or after July 1, 2027, the service retirement pension shall not be cancelled in the case of a service retirement pensioner who is re-employed as a teacher or an administrator on a temporary and non-annual basis or on an hourly basis, so long as the person does not work as a teacher or an administrator for compensation on more than 120 days in a school year. Such re-employment does not require contributions, result in service credit, or constitute active membership in the Fund.

(c-10) Until June 30, 2027, the service retirement pension of a service retirement pensioner shall not be cancelled if the service retirement pensioner is employed in a subject shortage area and the Employer that is employing the service retirement pensioner meets the following requirements:

(1) If the Employer has honorably dismissed, within the calendar year preceding the beginning of the school term for which it seeks to employ a service retirement pensioner under this subsection, any teachers who are legally qualified to hold positions in the subject shortage area and have not yet begun to receive their service retirement pensions under this Article, the vacant positions must first be tendered to those teachers.

(2) For a period of at least 90 days during the 6 months preceding the beginning of either the fall or spring term for which it seeks to employ a service retirement pensioner under this subsection, the Employer must, on an ongoing basis, (i) advertise its vacancies in the subject shortage area in employment bulletins published by college and university placement offices located near the school; (ii) search for teachers legally qualified to fill those vacancies through the Illinois Education Job Bank; and (iii) post all vacancies on the Employer's website and list the vacancy in an online job portal or database.

An Employer of a teacher who is unable to continue employment with the Employer because of documented illness, injury, or disability that occurred after being hired by the Employer under this subsection is exempt from the provisions of paragraph (2) for 90 school days. However, the Employer must on an ongoing basis comply with items (i), (ii), and (iii) of paragraph (2).

The Employer must submit documentation of its compliance with this subsection to the regional superintendent. Upon receiving satisfactory documentation from the Employer, the regional superintendent shall certify the Employer's compliance with this subsection to the Fund.

(c-15) If a service retirement pension is required to be canceled because the service retirement pensioner worked more than the number of days allowed under this Section in any school year, the service

retirement pension benefit shall be withheld on a pro rata basis for each day worked in excess of the number of days allowed under this Section.

If a service retirement pensioner who only teaches drivers education courses after regular school hours works more than 900 hours in any school year, the service retirement pension benefit shall be withheld on a pro rata basis for each period of 7.5 hours in excess of 900 hours.

(d) Notwithstanding Sections 1-103.1 and 17-157, the changes to this Section made by Public Act 90-32 apply without regard to whether termination of service occurred before the effective date of that Act and apply retroactively to August 23, 1989.

Notwithstanding Sections 1-103.1 and 17-157, the changes to this Section and Section 17-106 made by Public Act 92-599 apply without regard to whether termination of service occurred before June 28, 2002 (the effective date of Public Act 92-599).

Notwithstanding Sections 1-103.1 and 17-157, the changes to this Section made by Public Act 97-912 apply without regard to whether termination of service occurred before August 8, 2012 (the effective date of Public Act 97-912).

The changes made by this amendatory Act of the 104th General Assembly are retroactive to July 1, 2020. All service retirement pensioners whose service retirement pensions were canceled as a result of re-employment as a teacher pursuant to this Section during the period of July 1, 2020 through the effective date of this amendatory Act of the 104th General Assembly shall have their overpayments recalculated on a pro rata basis consistent with the changes made by this amendatory Act of the 104th General Assembly, and the difference between the initial overpayment and the recalculated overpayment shall be refunded to those service retirement pensioners with interest.

(Source: P.A. 102-1013, eff. 5-27-22; 102-1090, eff. 6-10-22; 103-154, eff. 6-30-23; 103-588, eff. 6-5-24.)

Article 2.

Section 2-5. The Illinois Pension Code is amended by changing Section 7-137.1 as follows:

(40 ILCS 5/7-137.1) (from Ch. 108 1/2, par. 7-137.1)

Sec. 7-137.1. Elected officials.

(a) A person holding an elective office who has elected to participate in the Fund while in that office may revoke that election and cease participating in the Fund by notifying the Board in writing before January 1, 1992.

Upon such revocation, the person shall forfeit all creditable service earned while holding that office, and the Board shall refund to the person, without interest, all employee contributions paid for the forfeited creditable service. The Board shall also refund or credit to the employing municipality, without interest, the employer contributions relating to the forfeited service, except those for death and disability.

(b) Notwithstanding the provisions of Sections 7-141 and 7-144, beginning January 1, 1992, a person who holds an elective office and has not elected to participate in the Fund with respect to that office (or has revoked his election to participate with respect to that office under subsection (a) of this Section) shall not be disqualified from receiving a retirement annuity by reason of holding such office, provided that the annuity is not based on any credits received for participating while holding that office.

(c) Notwithstanding any other provision, a person who holds an elective office and has not elected to participate in the Fund with respect to that office shall not be disqualified from receiving service credit for service in that elected office as long as:

(1) the member participated in a non-elected position with the employer for which the member is now an elected official;

(2) the employer has continued to make member contributions for that period of service; and

(3) there is no gap in service credit between the 2 positions.

(Source: P.A. 87-740.)

Article 3.

Section 3-5. The Illinois Pension Code is amended by changing Sections 13-207, 13-310, and 13-706 as follows:

(40 ILCS 5/13-207) (from Ch. 108 1/2, par. 13-207)

Sec. 13-207. "Salary": The salary paid to an employee for service to the District or to the Board, including salary paid for vacation and sick leave and any amounts deferred under a deferred compensation

plan established under this Code, but excluding (1) payment for unused vacation or sick leave, (2) overtime pay, (3) termination pay, and (4) any compensation in the form of benefits other than the salary. Salary for a member on a disability benefit is the salary on which the disability benefit is based.

(Source: P.A. 90-12, eff. 6-13-97.)

(40 ILCS 5/13-310) (from Ch. 108 1/2, par. 13-310)

Sec. 13-310. Ordinary disability benefit.

(a) Any employee who becomes disabled as the result of any cause other than injury or illness incurred in the performance of duty for the employer or any other employer, or while engaged in self-employment activities, shall be entitled to an ordinary disability benefit. The eligible period for this benefit shall be 25% of the employee's total actual service prior to the date of disability with a cumulative maximum period of 5 years.

(b) The benefit shall be allowed only if the employee files an application in writing with the Board that includes~~, and~~ a medical report ~~is submitted~~ by at least one licensed health care professional and the employee is examined, at least annually, by a licensed health care professional appointed by the Board ~~as part of the employee's application~~.

The benefit is not payable for any disability which begins during any period of unpaid leave of absence. No benefit shall be allowed for any period of disability prior to 30 days before application is made, unless the Board finds good cause for the delay in filing the application. The benefit shall not be paid during any period for which the employee receives or is entitled to receive any part of salary.

The benefit is not payable for any disability which begins during any period of absence from duty other than allowable vacation time in any calendar year. An employee whose disability begins during any such ineligible period of absence from service may not receive benefits until the employee recovers from the disability and is in service for at least 15 consecutive working days after such recovery.

In the case of an employee who first enters service on or after June 13, 1997, an ordinary disability benefit is not payable for the first 3 days of disability that would otherwise be payable under this Section if the disability does not continue for at least 11 additional days.

Beginning on August 18, 2005 (the effective date of Public Act 94-621) ~~this amendatory Act of the 94th General Assembly~~, an employee who first entered service on or after June 13, 1997 is also eligible for ordinary disability benefits on the 31st day after the last day worked, provided all sick leave is exhausted.

(c) The benefit shall be 50% of the employee's salary at the date of disability, and shall terminate when the earliest of the following occurs:

(1) The employee returns to work or receives a retirement annuity paid wholly or in part under this Article;

(2) The disability ceases;

(3) The employee willfully and continuously refuses to follow medical advice and treatment to enable the employee to return to work. However, this provision does not apply to an employee who relies in good faith on treatment by prayer through spiritual means alone in accordance with the tenets and practice of a recognized church or religious denomination, by a duly accredited practitioner thereof;

(4) The employee (i) refuses to submit to a reasonable physical examination within 30 days of application by a licensed health care professional appointed by the Board, (ii) in the case of chronic alcoholism, the employee refuses to join a rehabilitation program licensed by the Department of Public Health of the State of Illinois and certified by the Joint Commission on the Accreditation of Hospitals, (iii) fails or refuses to consent to and sign an authorization allowing the Board to receive copies of or to examine the employee's medical and hospital records, or (iv) fails or refuses to provide complete information regarding any other employment for compensation he or she has received since becoming disabled; or

(5) The eligibility ~~eligible~~ period for this benefit has been exhausted.

The first payment of the benefit shall be made not later than one month after the same has been granted, and subsequent payments shall be made at least monthly.

(Source: P.A. 102-210, eff. 7-30-21; 103-523, eff. 1-1-24; revised 7-17-24.)

(40 ILCS 5/13-706) (from Ch. 108 1/2, par. 13-706)

Sec. 13-706. Board powers and duties. The Board shall have the powers and duties set forth in this Section, in addition to such other powers and duties as may be provided in this Article and in this Code:

(a) To supervise collections. To see that all amounts specified in this Article to be applied to the Fund, from any source, are collected and applied.

(b) To notify of deductions. To notify the Clerk of the Water Reclamation District of the deductions to be made from the salaries of employees.

(c) To accept gifts. To accept by gift, grant, bequest or otherwise any money or property of any kind and use the same for the purposes of the Fund.

(d) To invest the reserves. To invest the reserves of the Fund in accordance with the provisions set forth in Section 1-109, 1-109.1, 1-109.2, 1-110, 1-111, 1-114, and 1-115 of this Code. Investments made in accordance with Section 1-113 of Article 1 of this Code shall be deemed prudent. The Board is also authorized to transfer securities to the Illinois State Board of Investment for the purpose of participation in any commingled investment fund as provided in Article 22A of this Code.

(e) To authorize payments. To consider and pass upon all applications for annuities and benefits; to authorize or suspend the payment of any annuity or benefit; to inquire into the validity and legality of any grant of annuity or benefit paid from or payable out of the Fund; to increase, reduce, or suspend any such annuity or benefit whenever the annuity or benefit, or any part thereof, was secured or granted, or the amount thereof fixed, as the result of misrepresentation, fraud, or error. No such annuity or benefit shall be permanently reduced or suspended until the affected annuitant or beneficiary is first notified of the proposed action and given an opportunity to be heard. No trustee of the Board shall vote upon that trustee's own personal claim for annuity, benefit or refund, or participate in the deliberations of the Board as to the validity of any such claim. The Board shall have exclusive original jurisdiction in all matters of claims for annuities, benefits and refunds.

(f) To submit an annual report. To submit a report in July of each year to the Board of Commissioners of the Water Reclamation District as of the close of business on December 31st of the preceding year. The report shall include the following:

(1) A balance sheet, showing the financial and actuarial condition of the Fund as of the end of the calendar year;

(2) A statement of receipts and disbursements during such year;

(3) A statement showing changes in the asset, liability, reserve and surplus accounts during such year;

(4) A detailed statement of investments as of the end of the year; and

(5) Any additional information as is deemed necessary for proper interpretation of the condition of the Fund.

(g) To subpoena witnesses and compel the production of records. To issue subpoenas to compel the attendance of witnesses to testify before the Board and to compel the production of documents and records upon any matter concerning the Fund, including, but not limited to, in conjunction with:

(1) a disability claim;

(2) an administrative review proceeding;

(3) an attempt to obtain information to assist in the collection of sums due to the Fund;

(4) obtaining any and all personal identifying information necessary for the administration of benefits;

(5) the determination of the death of a benefit recipient or a potential benefit recipient; or

(6) a felony forfeiture investigation.

The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the circuit courts of this State and shall be paid by the party seeking the subpoena. The Board may apply to any circuit court in the State for an order requiring compliance with a subpoena issued under this Section. Subpoenas issued under this Section shall be subject to the applicable provisions of the Code of Civil Procedure. The President or other members of the Board may administer oaths to witnesses. ~~To compel witnesses to attend and testify before it upon any matter concerning the Fund and allow witness fees not in excess of $6 for attendance upon any one day. The President and other members of the Board may administer oaths to witnesses.~~

(h) To appoint employees and consultants. To appoint such actuarial, medical, legal, investigational, clerical or financial employees and consultants as are necessary, and fix their compensation.

(i) To make rules. To make rules and regulations necessary for the administration of the affairs of the Fund.

(j) To waive guardianship. To waive the requirement of legal guardianship of a person under legal disability or any minor unmarried beneficiary of the Fund for a representative managing such

person or beneficiary's affairs, whenever the Board deems such waiver to be in the best interest of the person or beneficiary.

(k) To collect amounts due. To collect any amounts due to the Fund from any participant or beneficiary prior to payment of any annuity, benefit or refund.

(l) To invoke rule of offset. To offset against any amount payable to an employee or to any other person such sums as may be due to the Fund or may have been paid by the Fund due to misrepresentation, fraud or error.

(m) To assess and collect interest on amounts due to the Fund using the annual rate as shall from time to time be determined by the Board, compounded annually from the date of notification to the date of payment.

(Source: P.A. 103-523, eff. 1-1-24.)

Article 4.

Section 4-5. The Illinois Pension Code is amended by changing Section 17-114 as follows:

(40 ILCS 5/17-114) (from Ch. 108 1/2, par. 17-114)

Sec. 17-114. Computation of service.

(a) When computing days of validated service, contributors shall receive the greater of: (1) one day of service credit for each day for which they are paid salary representing a partial or a full day of employment rendered to an Employer or the Board; or (2) 10 days of service credit for each 10-day period of employment in which the contributor worked 50% or more of the regularly scheduled hours.

(b) When computing months of validated service, 17 or more days of service rendered to an Employer or the Board in a calendar month shall entitle a contributor to one month of service credit for purposes of this Article.

(c) When computing years of validated service rendered, 170 or more days of service in a fiscal year or 10 or more months of service in a fiscal year shall constitute one year of service credit.

(d) Notwithstanding subsections (b) and (c) of this Section, validated service in any fiscal year shall be that fraction of a year equal to the ratio of the number of days of service to 170 days.

(e) For purposes of this Section, no contributor shall earn (i) more than one year of service credit per fiscal year, (ii) more than one day of service credit per calendar day, or (iii) more than 10 days of service credit in a 2 calendar week period as determined by the Fund.

(Source: P.A. 99-176, eff. 7-29-15.)

Article 8.

Section 8-5. The Illinois Pension Code is amended by changing Section 1-107 as follows:

(40 ILCS 5/1-107) (from Ch. 108 1/2, par. 1-107)

Sec. 1-107. Indemnification of trustees, consultants, and employees of retirement systems and pension funds. Every retirement system, pension fund, or other system or fund established under this Code shall ~~may~~ indemnify and protect the trustees, staff, and consultants against all damage claims and suits, including the defense thereof, when damages are sought for negligent or wrongful acts alleged to have been committed in the scope of employment or under the direction of the trustees. However, the trustees, staff and consultants shall not be indemnified for willful ~~wilful~~ misconduct and gross negligence. Each board is authorized to insure against loss or liability of the trustees, staff and consultants which may result from these damage claims. This insurance shall be carried in a company which is licensed to write such coverage in this State.

(Source: P.A. 80-1364.)

Article 9.

Section 9-5. The Illinois Pension Code is amended by changing Section 6-151.1 as follows:

(40 ILCS 5/6-151.1) (from Ch. 108 1/2, par. 6-151.1)

Sec. 6-151.1. The General Assembly finds and declares that service in the Fire Department requires that firemen, in times of stress and danger, must perform unusual tasks; that by reason of their occupation, firemen are subject to exposure to great heat and to extreme cold in certain seasons while in performance of their duties; that by reason of their employment firemen are required to work in the midst of and are subject to heavy smoke fumes and carcinogenic, poisonous, toxic or chemical gases from fires; and that in the

course of their rescue and paramedic duties firemen are exposed to disabling infectious diseases, including AIDS, hepatitis C, and stroke. The General Assembly further finds and declares that all the aforementioned conditions exist and arise out of or in the course of such employment.

Any active fireman who has completed 7 or more years of service and is unable to perform his duties in the Fire Department by reason of heart disease, tuberculosis, breast cancer, any disease of the lungs or respiratory tract, AIDS, hepatitis C, stroke, or a contagious staph infection, including methicillin-resistant Staphylococcus aureus (MRSA), resulting from his service as a fireman, shall be entitled to receive an occupational disease disability benefit during any period of such disability for which he does not have a right to receive salary.

Any active fireman who has completed 7 or more years of service and is unable to perform his duties in the fire department by reason of a disabling cancer, which develops or manifests itself during a period while the fireman is in the service of the department, shall be entitled to receive an occupational disease disability benefit during any period of such disability for which he does not have a right to receive salary. In order to receive this occupational disease disability benefit, the type of cancer involved must be a type which may be caused by exposure to heat, radiation or a known carcinogen as defined by the International Agency for Research on Cancer.

Any fireman receiving a retirement annuity shall be entitled to an occupational disease disability benefit under this Section if the fireman (1) has not reached the age of compulsory retirement, (2) has not been receiving a retirement annuity for more than 5 years, and (3) has a condition that would have qualified the fireman for an occupational disease disability benefit under this Section if he or she was an active fireman. A fireman who receives an occupational disease disability benefit in accordance with this paragraph may not receive a retirement annuity during the period in which he or she receives an occupational disease disability benefit. The occupational disease disability benefit shall terminate upon the fireman reaching the age of compulsory retirement.

Any fireman who shall enter the service after the effective date of this amendatory Act shall be examined by one or more practicing physicians appointed by the Board, and if that examination discloses impairment of the heart, lungs, or respiratory tract, or the existence of AIDS, hepatitis C, stroke, cancer, or a contagious staph infection, including methicillin-resistant Staphylococcus aureus (MRSA), then the fireman shall not be entitled to receive an occupational disease disability benefit unless and until a subsequent examination reveals no such impairment, AIDS, hepatitis C, stroke, cancer, or contagious staph infection, including methicillin-resistant Staphylococcus aureus (MRSA).

The occupational disease disability benefit shall be 65% of the fireman's salary at the time of his removal from the Department payroll. However, beginning January 1, 1994, no occupational disease disability benefit that has been payable under this Section for at least 10 years shall be less than 50% of the current salary attached from time to time to the rank and grade held by the fireman at the time of his removal from the Department payroll, regardless of whether that removal occurred before the effective date of this amendatory Act of 1993.

Such fireman also shall have a right to receive child's disability benefit of $30 per month on account of each unmarried child who is less than 18 years of age or handicapped, dependent upon the fireman for support, and either the issue of the fireman or legally adopted by him. The total amount of child's disability benefit payable to the fireman, when added to his occupational disease disability benefit, shall not exceed 75% of the amount of salary which he was receiving at the time of the grant of occupational disease disability benefit.

The first payment of occupational disease disability benefit or child's disability benefit shall be made not later than one month after the benefit is granted. Each subsequent payment shall be made not later than one month after the date of the latest payment.

Occupational disease disability benefit shall be payable during the period of the disability until the fireman reaches the age of compulsory retirement. Child's disability benefit shall be paid to such a fireman during the period of disability until such child or children attain age 18 or marry, whichever event occurs first; except that attainment of age 18 by a child who is so physically or mentally handicapped as to be dependent upon the fireman for support, shall not render the child ineligible for child's disability benefit. The fireman thereafter shall receive such annuity or annuities as are provided for him in accordance with other provisions of this Article.

(Source: P.A. 102-91, eff. 7-9-21; 102-1064, eff. 6-10-22.)

Article 11.

Section 11-5. The Illinois Pension Code is amended by changing Section 15-148 as follows:
(40 ILCS 5/15-148) (from Ch. 108 1/2, par. 15-148)

Sec. 15-148. Survivors insurance benefits; general ~~benefits—General~~ provisions. The survivors annuity is payable monthly. Any annuity due but unpaid upon the death of the annuitant, shall be paid to the annuitant's estate.

A person who becomes entitled to more than one survivors insurance benefit because of the death of 2 or more persons shall receive only the largest of the benefits; except that this limitation does not apply to a survivors insurance beneficiary who is entitled to a survivor's annuity by reason of a mental or physical disability.

A survivors insurance beneficiary or the personal representative of the estate of a deceased survivors insurance beneficiary or the personal representative of a survivors insurance beneficiary who is under a legal disability may waive the right to receive survivorship benefits, provided written notice of the waiver is given by the beneficiary or representative to the board within 6 months after the System notified that person of the benefits payable upon the death of the participant or annuitant and before any payment is made pursuant to an application filed by such person.
(Source: P.A. 92-424, eff. 8-17-01.)

Article 12.

Section 12-5. The Illinois Pension Code is amended by changing Section 7-172 as follows:
(40 ILCS 5/7-172) (from Ch. 108 1/2, par. 7-172)

Sec. 7-172. Contributions by participating municipalities and participating instrumentalities.

(a) Each participating municipality and each participating instrumentality shall make payment to the fund as follows:

1. municipality contributions in an amount determined by applying the municipality contribution rate to each payment of earnings paid to each of its participating employees;

2. an amount equal to the employee contributions provided by paragraph (a) of Section 7-173, whether or not the employee contributions are withheld as permitted by that Section;

3. all accounts receivable, together with interest charged thereon, as provided in Section 7-209, and any amounts due under subsection (a-5) of Section 7-144;

4. if it has no participating employees with current earnings, an amount payable which, over a closed period of 20 years for participating municipalities and 10 years for participating instrumentalities, will amortize, at the effective rate for that year, any unfunded obligation. The unfunded obligation shall be computed as provided in paragraph 2 of subsection (b);

5. if it has fewer than 7 participating employees or a negative balance in its municipality reserve, the greater of (A) an amount payable that, over a period of 20 years, will amortize at the effective rate for that year any unfunded obligation, computed as provided in paragraph 2 of subsection (b) or (B) the amount required by paragraph 1 of this subsection (a).

(b) A separate municipality contribution rate shall be determined for each calendar year for all participating municipalities together with all instrumentalities thereof. The municipality contribution rate shall be determined for participating instrumentalities as if they were participating municipalities. The municipality contribution rate shall be the sum of the following percentages:

1. The percentage of earnings of all the participating employees of all participating municipalities and participating instrumentalities which, if paid over the entire period of their service, will be sufficient when combined with all employee contributions available for the payment of benefits, to provide all annuities for participating employees, and the $3,000 death benefit payable under Sections 7-158 and 7-164, such percentage to be known as the normal cost rate.

2. The percentage of earnings of the participating employees of each participating municipality and participating instrumentalities necessary to adjust for the difference between the present value of all benefits, excluding temporary and total and permanent disability and death benefits, to be provided for its participating employees and the sum of its accumulated municipality contributions and the accumulated employee contributions and the present value of expected future employee and municipality contributions pursuant to subparagraph 1 of this paragraph (b). This adjustment shall be spread over a period determined by the Board, not to exceed 30 years for participating municipalities or 10 years for participating instrumentalities.

3. The percentage of earnings of the participating employees of all municipalities and participating instrumentalities necessary to provide the present value of all temporary and total and permanent disability benefits granted during the most recent year for which information is available.

4. The percentage of earnings of the participating employees of all participating municipalities and participating instrumentalities necessary to provide the present value of the net single sum death benefits expected to become payable from the reserve established under Section 7-206 during the year for which this rate is fixed.

5. The percentage of earnings necessary to meet any deficiency arising in the Terminated Municipality Reserve.

(c) A separate municipality contribution rate shall be computed for each participating municipality or participating instrumentality for its sheriff's law enforcement employees.

A separate municipality contribution rate shall be computed for the sheriff's law enforcement employees of each forest preserve district that elects to have such employees. For the period from January 1, 1986 to December 31, 1986, such rate shall be the forest preserve district's regular rate plus 2%.

In the event that the Board determines that there is an actuarial deficiency in the account of any municipality with respect to a person who has elected to participate in the Fund under Section 3-109.1 of this Code, the Board may adjust the municipality's contribution rate so as to make up that deficiency over such reasonable period of time as the Board may determine.

(d) The Board may establish a separate municipality contribution rate for all employees who are program participants employed under the federal Comprehensive Employment Training Act by all of the participating municipalities and instrumentalities. The Board may also provide that, in lieu of a separate municipality rate for these employees, a portion of the municipality contributions for such program participants shall be refunded or an extra charge assessed so that the amount of municipality contributions retained or received by the fund for all CETA program participants shall be an amount equal to that which would be provided by the separate municipality contribution rate for all such program participants. Refunds shall be made to prime sponsors of programs upon submission of a claim therefor and extra charges shall be assessed to participating municipalities and instrumentalities. In establishing the municipality contribution rate as provided in paragraph (b) of this Section, the use of a separate municipality contribution rate for program participants or the refund of a portion of the municipality contributions, as the case may be, may be considered.

(e) Computations of municipality contribution rates for the following calendar year shall be made prior to the beginning of each year, from the information available at the time the computations are made, and on the assumption that the employees in each participating municipality or participating instrumentality at such time will continue in service until the end of such calendar year at their respective rates of earnings at such time.

(f) Any municipality which is the recipient of State allocations representing that municipality's contributions for retirement annuity purposes on behalf of its employees as provided in Section 12-21.16 of the Illinois Public Aid Code shall pay the allocations so received to the Board for such purpose. Estimates of State allocations to be received during any taxable year shall be considered in the determination of the municipality's tax rate for that year under Section 7-171. If a special tax is levied under Section 7-171, none of the proceeds may be used to reimburse the municipality for the amount of State allocations received and paid to the Board. Any multiple-county or consolidated health department which receives contributions from a county under Section 11.2 of "An Act in relation to establishment and maintenance of county and multiple-county health departments", approved July 9, 1943, as amended, or distributions under Section 3 of the Department of Public Health Act, shall use these only for municipality contributions by the health department.

(g) Municipality contributions for the several purposes specified shall, for township treasurers and employees in the offices of the township treasurers who meet the qualifying conditions for coverage hereunder, be allocated among the several school districts and parts of school districts serviced by such treasurers and employees in the proportion which the amount of school funds of each district or part of a district handled by the treasurer bears to the total amount of all school funds handled by the treasurer.

From the funds subject to allocation among districts and parts of districts pursuant to the School Code, the trustees shall withhold the proportionate share of the liability for municipality contributions imposed upon such districts by this Section, in respect to such township treasurers and employees and remit the same to the Board.

The municipality contribution rate for an educational service center shall initially be the same rate for each year as the regional office of education or school district which serves as its administrative agent. When actuarial data become available, a separate rate shall be established as provided in subparagraph (i) of this Section.

The municipality contribution rate for a public agency, other than a vocational education cooperative, formed under the Intergovernmental Cooperation Act shall initially be the average rate for the municipalities which are parties to the intergovernmental agreement. When actuarial data become available, a separate rate shall be established as provided in subparagraph (i) of this Section.

(h) Each participating municipality and participating instrumentality shall make the contributions in the amounts provided in this Section in the manner prescribed from time to time by the Board and all such contributions shall be obligations of the respective participating municipalities and participating instrumentalities to this fund. The failure to deduct any employee contributions shall not relieve the participating municipality or participating instrumentality of its obligation to this fund. Delinquent payments of contributions due under this Section may, with interest, be recovered by civil action against the participating municipalities or participating instrumentalities. Municipality contributions, other than the amount necessary for employee contributions, for periods of service by employees from whose earnings no deductions were made for employee contributions to the fund, may be charged to the municipality reserve for the municipality or participating instrumentality.

(i) Contributions by participating instrumentalities shall be determined as provided herein except that the percentage derived under subparagraph 2 of paragraph (b) of this Section, and the amount payable under subparagraph 4 of paragraph (a) of this Section, shall be based on an amortization period of 10 years.

(j) Notwithstanding the other provisions of this Section, the additional unfunded liability accruing as a result of Public Act 94-712 shall be amortized over a period of 30 years beginning on January 1 of the second calendar year following the calendar year in which Public Act 94-712 takes effect, except that the employer may provide for a longer amortization period by adopting a resolution or ordinance specifying a 35-year or 40-year period and submitting a certified copy of the ordinance or resolution to the fund no later than June 1 of the calendar year following the calendar year in which Public Act 94-712 takes effect.

(k) If the amount of a participating employee's reported earnings for any of the 12-month periods used to determine the final rate of earnings exceeds the employee's 12-month reported earnings with the same employer for the previous year by the greater of 6% or 1.5 times the annual increase in the Consumer Price Index-U, as established by the United States Department of Labor for the preceding September, the participating municipality or participating instrumentality that paid those earnings shall pay to the Fund, in addition to any other contributions required under this Article, the present value of the increase in the pension resulting from the portion of the increase in reported earnings that is in excess of the greater of 6% or 1.5 times the annual increase in the Consumer Price Index-U, as determined by the Fund. This present value shall be computed on the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the Fund that is available at the time of the computation.

Whenever it determines that a payment is or may be required under this subsection (k), the fund shall calculate the amount of the payment and bill the participating municipality or participating instrumentality for that amount. The bill shall specify the calculations used to determine the amount due. If the participating municipality or participating instrumentality disputes the amount of the bill, it may, within 30 days after receipt of the bill, apply to the fund in writing for a recalculation. The application must specify in detail the grounds of the dispute. Upon receiving a timely application for recalculation, the fund shall review the application and, if appropriate, recalculate the amount due. The participating municipality and participating instrumentality contributions required under this subsection (k) may be paid in the form of a lump sum within 90 days after receipt of the bill. If the participating municipality and participating instrumentality contributions are not paid within 90 days after receipt of the bill, then interest will be charged at a rate equal to the fund's annual actuarially assumed rate of return on investment compounded annually from the 91st day after receipt of the bill. Payments must be concluded within 7 ~~3~~ years after receipt of the bill by the participating municipality or participating instrumentality.

When assessing payment for any amount due under this subsection (k), the fund shall exclude earnings increases resulting from overload or overtime earnings.

When assessing payment for any amount due under this subsection (k), the fund shall exclude earnings increases resulting from payments for unused vacation time, but only for payments for unused vacation time made in the final 3 months of the final rate of earnings period.

When assessing payment for any amount due under this subsection (k), the fund shall also exclude earnings increases attributable to standard employment promotions resulting in increased responsibility and workload.

When assessing payment for any amount due under this subsection (k), the fund shall exclude reportable earnings increases resulting from periods where the member was paid through workers' compensation.

This subsection (k) does not apply to earnings increases due to amounts paid as required by federal or State law or court mandate or to earnings increases due to the participating employee returning to the regular number of hours worked after having a temporary reduction in the number of hours worked.

This subsection (k) does not apply to earnings increases paid to individuals under contracts or collective bargaining agreements entered into, amended, or renewed before January 1, 2012 (the effective date of Public Act 97-609), earnings increases paid to members who are 10 years or more from retirement eligibility, or earnings increases resulting from an increase in the number of hours required to be worked.

When assessing payment for any amount due under this subsection (k), the fund shall also exclude earnings attributable to personnel policies adopted before January 1, 2012 (the effective date of Public Act 97-609) as long as those policies are not applicable to employees who begin service on or after January 1, 2012 (the effective date of Public Act 97-609).

The change made to this Section by Public Act 100-139 is a clarification of existing law and is intended to be retroactive to January 1, 2012 (the effective date of Public Act 97-609).
(Source: P.A. 102-849, eff. 5-13-22; 103-464, eff. 8-4-23.)

Article 13.

Section 13-5. The Illinois Pension Code is amended by changing Section 16-204 as follows:
(40 ILCS 5/16-204)

Sec. 16-204. Optional defined contribution benefit. As soon as practicable after the effective date of this amendatory Act of the 100th General Assembly, the System shall offer a defined contribution benefit to active full-time or part-time contractual members of the System who are employed by an employer eligible to participate in the defined contribution benefit under applicable law. The defined contribution benefit shall be an optional benefit to any full-time or part-time contractual member who chooses to participate. The defined contribution benefit shall collect optional employee and optional employer contributions into an account and shall offer investment options to the participant. The benefit under this Section shall be operated in full compliance with any applicable State and federal laws, and the System shall utilize generally accepted practices in creating and maintaining the benefit for the best interest of the participants. In administering the defined contribution benefit, the System shall require that the defined contribution benefit recordkeeper agree that, in performing services with respect to the defined contribution benefit, the recordkeeper: (i) will not use information received as a result of providing services with respect to the defined contribution benefit or the participants in the defined contribution benefit to solicit the participants in the defined contribution benefit for the purpose of cross-selling nonplan products and services, unless in response to a request by a participant in the defined contribution benefit; and (ii) will not promote, recommend, endorse, or solicit participants in the defined contribution benefit to purchase any financial products or services outside of the defined contribution benefit, except that links to parts of the recordkeeper's website that are generally available to the public, are about commercial products, and may be encountered by a participant in the regular course of navigating the recordkeeper's website will not constitute a violation of this item (ii). The System may use funds from the employee and employer contributions to defray any and all costs of creating and maintaining the benefit. In addition, the System may use funds provided under Section 16-158 of this Code to defray any and all costs of creating and maintaining the benefit and then shall reimburse those costs from funds received from the employee and employer contributions under this Section. All employers must comply with the reporting and administrative functions established by the System and are required to implement the benefits established under this Section. The System shall produce an annual report on the participation in the benefit and shall make the report public.

As soon as is practicable on or after January 1, 2022, the System shall automatically enroll any employee who first becomes an active full-time or part-time contractual member ~~or participant~~ in the System. A member automatically enrolled under this Section shall have 3% of his or her pre-tax ~~gross~~ compensation ~~for each compensation period~~ deferred into his or her deferred compensation account~~, unless~~

~~the member otherwise instructs the System on forms approved by the System~~. A member may elect, in a manner provided for by the System, to not participate in the defined contribution benefit or to increase or reduce the amount of pre-tax ~~gross~~ compensation contributed, consistent with State or federal law. A member shall be automatically enrolled in the benefit beginning the first day of the pay period following the close of the notice period, or as soon as practicable, unless the employee elects otherwise within the notice period ~~member's 30th day of employment~~. For the purposes of this Section, "notice period" means a reasonable period of time after the employee is provided with an automatic enrollment notice as required under Section 414(w) of the Internal Revenue Code of 1986, as amended. An active full-time or part-time contractual ~~A~~ member who has been automatically enrolled in the benefit may elect, within 90 days following the member's initial contribution ~~days of enrollment~~, to withdraw ~~from~~ the contribution ~~benefit~~ and receive a refund of amounts deferred, as adjusted for ~~plus or minus any~~ applicable earnings and fees. A member making such an election shall forfeit all employer matching contributions, if any, made with respect to the initial contribution and the forfeited amounts shall be used to defray plan expenses ~~earnings, investment fees, and administrative fees~~. Any refunded amount shall be included in the member's gross income for the taxable year in which the refund is issued.

On or after January 1, 2023, the System may elect to increase the automatic annual contributions under this Section. The increase in the rate of contribution, however, shall not exceed 2% of a member's pre-tax ~~gross~~ compensation per year, and at no time shall any total contribution exceed any contribution limits established by State or federal law.

Notwithstanding any other provision of this Section, active members eligible to participate in the defined contribution benefit do not include employees of a department as defined in Section 14-103.04.
(Source: P.A. 102-540, eff. 8-20-21; 103-552, eff. 8-11-23.)

Article 14.

Section 14-5. The Illinois Pension Code is amended by changing Sections 3-110.14 and 7-139.1a as follows:

(40 ILCS 5/3-110.14)

Sec. 3-110.14. Transfer to Article 7.

(a) On and after July 1, 2022 but no later than December 1, 2023, a participating employee who is actively employed as a sheriff's law enforcement employee under Article 7 may make a written election to transfer up to 10 years of creditable service from a fund established under this Article to the Illinois Municipal Retirement Fund established under Article 7. Upon receiving a written election by a participant under this Section, the creditable service shall be transferred to the Illinois Municipal Retirement Fund as soon as practicable upon payment by the police pension fund to the Illinois Municipal Retirement Fund of an amount equal to:

(1) the amounts accumulated to the credit of the applicant on the books of the fund on the date of the transfer; and

(2) employer contributions in an amount equal to the amount determined under paragraph (1).

Participation in the police pension fund with respect to the service to be transferred shall terminate on the date of transfer. This Section does not allow reinstatement of credits in this Article that were previously forfeited.

(b) On and after the effective date of this amendatory Act of the 104th General Assembly but no later than 6 months after the effective date of this amendatory Act of the 104th General Assembly, a participating employee who is actively employed as a sheriff's law enforcement employee under Article 7 may make a written election to transfer creditable service from a fund established under this Article to the Illinois Municipal Retirement Fund established under Article 7. Upon receiving a written election by a participant under this Section, the creditable service shall be transferred to the Illinois Municipal Retirement Fund as soon as practicable upon payment by the police pension fund to the Illinois Municipal Retirement Fund of an amount equal to:

(1) the amounts accumulated to the credit of the applicant on the books of the fund on the date of the transfer; and

(2) employer contributions in an amount equal to the amount determined under paragraph (1).

Participation in the police pension fund with respect to the service to be transferred shall terminate on the date of transfer. This Section does not allow reinstatement of credits in this Article that were previously forfeited.

(Source: P.A. 102-1061, eff. 6-10-22.)

(40 ILCS 5/7-139.1a)

Sec. 7-139.1a. Transfer from Article 3.

(a) On and after July 1, 2022 but no later than January 1, 2023, a participating sheriff's law enforcement employee may elect to transfer up to 10 years of service credit to the Fund as set forth in Section 3-110.14. To establish creditable service under this Section, the sheriff's law enforcement employee may elect to do either of the following:

(1) pay to the Fund an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the Fund under Section 3-110.14 and the amounts that would have been contributed had such contributions been made at the rates applicable to a sheriff's law enforcement employee under this Article, plus (ii) interest thereon at the actuarially assumed rate, compounded annually, from the date of service to the date of payment; or

(2) have the amount of his or her creditable service established under this Section reduced by an amount corresponding to the amount by which (i) the employer and employee contributions that would have been required if he or she had participated in the Fund as a sheriff's law enforcement employee during the period for which credit is being transferred, plus interest thereon at the actuarially assumed rate, compounded annually, from the date of termination of the service for which credit is being transferred to the date of payment, exceeds (ii) the amount actually transferred to the Fund.

Notwithstanding the amount transferred by the Article 3 fund pursuant to Section 3-110.14, in no event shall the service credit established under this Section exceed the lesser of 10 years or the actual amount of service credit that had been earned in the Article 3 fund. If an amount greater than the amount described under paragraph (1) is transferred to the Fund, the additional amount shall be credited to the account of the sheriff's law enforcement employee's employer.

(b) On and after the effective date of this amendatory Act of the 104th General Assembly but no later than 6 months after the effective date of this amendatory Act of the 104th General Assembly, a participating sheriff's law enforcement employee may elect to transfer service credit to the Fund as set forth in Section 3-110.14. To establish creditable service under this Section, the sheriff's law enforcement employee may elect to do either of the following:

(1) pay to the Fund an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the Fund under Section 3-110.14 and the amounts that would have been contributed had such contributions been made at the rates applicable to a sheriff's law enforcement employee under this Article, plus (ii) interest thereon at the actuarially assumed rate, compounded annually, from the date of service to the date of payment; or

(2) have the amount of his or her creditable service established under this Section reduced by an amount corresponding to the amount by which (i) the employer and employee contributions that would have been required if he or she had participated in the Fund as a sheriff's law enforcement employee during the period for which credit is being transferred, plus interest thereon at the actuarially assumed rate, compounded annually, from the date of termination of the service for which credit is being transferred to the date of payment, exceeds (ii) the amount actually transferred to the Fund.

Notwithstanding the amount transferred by the Article 3 fund pursuant to Section 3-110.14, in no event shall the service credit established under this Section exceed the actual amount of service credit that had been earned in the Article 3 fund. If an amount greater than the amount described under paragraph (1) is transferred to the Fund, the additional amount shall be credited to the account of the sheriff's law enforcement employee's employer.

(Source: P.A. 102-1061, eff. 6-10-22.)

Article 15.

Section 15-5. The Illinois Pension Code is amended by changing Section 15-112 as follows:

(40 ILCS 5/15-112) (from Ch. 108 1/2, par. 15-112)

Sec. 15-112. Final rate of earnings. "Final rate of earnings":

(a) This subsection (a) applies only to a Tier 1 member.

For an employee who is paid on an hourly basis or who receives an annual salary in installments during 12 months of each academic year, the average annual earnings during the 48 consecutive calendar

month period ending with the last day of final termination of employment or the 4 consecutive academic years of service in which the employee's earnings were the highest, whichever is greater. For any other employee, the average annual earnings during the 4 consecutive academic years of service in which his or her earnings were the highest. For an employee with less than 48 months or 4 consecutive academic years of service, the average earnings during his or her entire period of service. The earnings of an employee with more than 36 months of service under item (a) of Section 15-113.1 prior to the date of becoming a participant are, for such period, considered equal to the average earnings during the last 36 months of such service.

(b) This subsection (b) applies to a Tier 2 member.

For an employee who is paid on an hourly basis or who receives an annual salary in installments during 12 months of each academic year, the average annual earnings obtained by dividing by 8 the total earnings of the employee during the 96 consecutive months in which the total earnings were the highest within the last 120 months prior to termination or the average annual earnings during the 8 consecutive academic years of service within the 10 years of service prior to termination in which the employee's earnings were the highest, whichever is greater.

For any other employee, the average annual earnings during the 8 consecutive academic years of service within the 10 years of service prior to termination in which the employee's earnings were the highest. For an employee with less than 96 consecutive months or 8 consecutive academic years of service, whichever is necessary, the average earnings during his or her entire period of service.

The changes made to this subsection (b) by this amendatory Act of the 104th General Assembly are corrections and clarifications of existing law and are intended to be retroactive to January 1, 2011 (the effective date of Public Act 96-1490), notwithstanding the provisions of Section 1-103.1 of this Code.

(c) For an employee on leave of absence with pay, or on leave of absence without pay who makes contributions during such leave, earnings are assumed to be equal to the basic compensation on the date the leave began.

(d) For an employee on disability leave, earnings are assumed to be equal to the basic compensation on the date disability occurs or the average earnings during the 24 months immediately preceding the month in which disability occurs, whichever is greater.

(e) For a Tier 1 member who retires on or after August 22, 1997 (the effective date of Public Act 90-511) ~~this amendatory Act of 1997~~ with at least 20 years of service as a firefighter or police officer under this Article, the final rate of earnings shall be the annual rate of earnings received by the participant on his or her last day as a firefighter or police officer under this Article, if that is greater than the final rate of earnings as calculated under the other provisions of this Section.

(f) If a Tier 1 member is an employee for at least 6 months during the academic year in which his or her employment is terminated, the annual final rate of earnings shall be 25% of the sum of (1) the annual basic compensation for that year, and (2) the amount earned during the 36 months immediately preceding that year, if this is greater than the final rate of earnings as calculated under the other provisions of this Section.

(g) In the determination of the final rate of earnings for an employee, that part of an employee's earnings for any academic year beginning after June 30, 1997, which exceeds the employee's earnings with that employer for the preceding year by more than 20% ~~20 percent~~ shall be excluded; in the event that an employee has more than one employer this limitation shall be calculated separately for the earnings with each employer. In making such calculation, only the basic compensation of employees shall be considered, without regard to vacation or overtime or to contracts for summer employment. Beginning September 1, 2024, this subsection (g) also applies to an employee who has been employed at 1/2 time or less for 3 or more years.

(h) The following are not considered as earnings in determining the final rate of earnings: (1) severance or separation pay, (2) retirement pay, (3) payment for unused sick leave, and (4) payments from an employer for the period used in determining the final rate of earnings for any purpose other than (i) services rendered, (ii) leave of absence or vacation granted during that period, and (iii) vacation of up to 56 work days allowed upon termination of employment; except that, if the benefit has been collectively bargained between the employer and the recognized collective bargaining agent pursuant to the Illinois Educational Labor Relations Act, payment received during a period of up to 2 academic years for unused sick leave may be considered as earnings in accordance with the applicable collective bargaining agreement, subject to the 20% increase limitation of this Section. Any unused sick leave considered as earnings under this Section shall not be taken into account in calculating service credit under Section 15-113.4.

(i) Intermittent periods of service shall be considered as consecutive in determining the final rate of earnings.
(Source: P.A. 103-548, eff. 8-11-23; revised 7-18-24.)

Article 17.

Section 17-5. The Illinois Pension Code is amended by changing Section 22C-116 as follows:
(40 ILCS 5/22C-116)
Sec. 22C-116. Conduct and administration of elections; terms of office.

(a) For the election of the permanent trustees, the transition board shall administer the initial elections and the permanent board shall administer all subsequent elections. Each board shall develop and implement such procedures as it determines to be appropriate for the conduct of such elections. For the purposes of obtaining information necessary to conduct elections under this Section, participating pension funds shall cooperate with the Fund.

(b) All nominations for election shall be by petition. Each petition for a trustee shall be executed as follows:

(1) for trustees to be elected by the mayors and presidents of municipalities or fire protection districts that have participating pension funds, by at least 20 such mayors and presidents; except that this item (1) shall apply only with respect to participating pension funds;

(2) for trustees to be elected by participants, by at least 200 ~~400~~ participants; and

(3) for trustees to be elected by beneficiaries, by at least 100 beneficiaries.

(c) A separate ballot shall be used for each class of trustee. The board shall prepare and send ballots and ballot envelopes to eligible voters in accordance with rules adopted by the board. The ballots shall contain the names of all candidates in alphabetical order.

Eligible voters, upon receipt of the ballot, shall vote the ballot and place it in the ballot envelope, seal the envelope, and return the ballot to the Fund.

The board shall set a final date for ballot return, and ballots received prior to that date in a ballot envelope shall be valid ballots.

The board shall set a day for counting the ballots and name judges and clerks of election to conduct the count of ballots and shall make any rules necessary for the conduct of the count.

The candidate or candidates receiving the highest number of votes for each class of trustee shall be elected. In the case of a tie vote, the winner shall be determined in accordance with procedures developed by the Department of Insurance.

In lieu of or in addition to conducting elections via mail balloting as described in this Section, the board may ~~instead~~ adopt rules to provide for elections to be carried out ~~solely~~ via Internet balloting, ~~or~~ phone balloting, or a combination thereof. Nothing in this Section prohibits the Fund from contracting with a third party to administer the election in accordance with this Section.

(d) At any election, voting shall be as follows:

(1) Each person authorized to vote for an elected trustee may cast one vote for each related position for which such person is entitled to vote and may cast such vote for any candidate or candidates on the ballot for such trustee position.

(2) If only one candidate for each position is properly nominated in petitions received, that candidate shall be deemed the winner and no election under this Section shall be required.

(3) The results shall be entered in the minutes of the first meeting of the board following the tally of votes.

(e) The initial election for permanent trustees shall be held and the permanent board shall be seated no later than 12 months after the effective date of this amendatory Act of the 101st General Assembly. Each subsequent election shall be held no later than 30 days prior to the end of the term of the incumbent trustees.

(f) The elected trustees shall each serve for terms of 4 years commencing on the first business day of the first month after election; except that the terms of office of the initially elected trustees shall be as follows:

(1) One trustee elected pursuant to item (1) of subsection (b) of Section 22C-115 shall serve for a term of 2 years and 2 trustees elected pursuant to item (1) of subsection (b) of Section 22C-115 shall serve for a term of 4 years;

(2) One trustee elected pursuant to item (2) of subsection (b) of Section 22C-115 shall serve for a term of 2 years and 2 trustees elected pursuant to item (2) of subsection (b) of Section 22C-115 shall serve for a term of 4 years; and

(3) The trustee elected pursuant to item (3) of subsection (b) of Section 22C-115 shall serve for a term of 2 years.

(g) The trustees appointed pursuant to items (4) and (5) of subsection (b) of Section 22C-115 shall each serve for a term of 4 years commencing on the first business day of the first month after the election of the elected trustees.

(h) A member of the board who was elected pursuant to item (1) of subsection (b) of Section 22C-115 who ceases to serve as a mayor, president, chief executive officer, chief financial officer, or other officer, executive, or department head of a municipality or fire protection district that has a participating pension fund shall not be eligible to serve as a member of the board and his or her position shall be deemed vacant. A member of the board who was elected by the participants of participating pension funds who ceases to be a participant may serve the remainder of his or her elected term.

For a vacancy of an elected trustee, the vacancy shall be filled by appointment by the board as follows: a vacancy of a member elected pursuant to item (1) of subsection (b) of Section 22C-115 shall be filled by a mayor, president, chief executive officer, chief financial officer, or other officer, executive, or department head of a municipality or fire protection district that has a participating pension fund; a vacancy of a member elected pursuant to item (2) of subsection (b) of Section 22C-115 shall be filled by a participant of a participating pension fund; and a vacancy of a member elected under item (3) of subsection (b) of Section 22C-115 shall be filled by a beneficiary of a participating pension fund. A trustee appointed to fill the vacancy of an elected trustee shall serve until a successor is elected. Special elections to fill the remainder of an unexpired term vacated by an elected trustee shall be held concurrently with and in the same manner as the next regular election for an elected trustee position.

Vacancies among the appointed trustees shall be filled for unexpired terms by appointment in like manner as for the original appointments.

(Source: P.A. 103-552, eff. 8-11-23.)

Article 18.

Section 18-5. The Illinois Pension Code is amended by changing Sections 15-155 and 16-158 as follows:

(40 ILCS 5/15-155) (from Ch. 108 1/2, par. 15-155)

Sec. 15-155. Employer contributions.

(a) The State of Illinois shall make contributions by appropriations of amounts which, together with the other employer contributions from trust, federal, and other funds, employee contributions, income from investments, and other income of this System, will be sufficient to meet the cost of maintaining and administering the System on a 90% funded basis in accordance with actuarial recommendations.

The Board shall determine the amount of State contributions required for each fiscal year on the basis of the actuarial tables and other assumptions adopted by the Board and the recommendations of the actuary, using the formula in subsection (a-1).

(a-1) For State fiscal years 2012 through 2045, the minimum contribution to the System to be made by the State for each fiscal year shall be an amount determined by the System to be sufficient to bring the total assets of the System up to 90% of the total actuarial liabilities of the System by the end of State fiscal year 2045. In making these determinations, the required State contribution shall be calculated each year as a level percentage of payroll over the years remaining to and including fiscal year 2045 and shall be determined under the projected unit credit actuarial cost method.

For each of State fiscal years 2018, 2019, and 2020, the State shall make an additional contribution to the System equal to 2% of the total payroll of each employee who is deemed to have elected the benefits under Section 1-161 or who has made the election under subsection (c) of Section 1-161.

A change in an actuarial or investment assumption that increases or decreases the required State contribution and first applies in State fiscal year 2018 or thereafter shall be implemented in equal annual amounts over a 5-year period beginning in the State fiscal year in which the actuarial change first applies to the required State contribution.

A change in an actuarial or investment assumption that increases or decreases the required State contribution and first applied to the State contribution in fiscal year 2014, 2015, 2016, or 2017 shall be implemented:

(i) as already applied in State fiscal years before 2018; and

(ii) in the portion of the 5-year period beginning in the State fiscal year in which the actuarial change first applied that occurs in State fiscal year 2018 or thereafter, by calculating the change in equal annual amounts over that 5-year period and then implementing it at the resulting annual rate in each of the remaining fiscal years in that 5-year period.

For State fiscal years 1996 through 2005, the State contribution to the System, as a percentage of the applicable employee payroll, shall be increased in equal annual increments so that by State fiscal year 2011, the State is contributing at the rate required under this Section.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2006 is $166,641,900.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2007 is $252,064,100.

For each of State fiscal years 2008 through 2009, the State contribution to the System, as a percentage of the applicable employee payroll, shall be increased in equal annual increments from the required State contribution for State fiscal year 2007, so that by State fiscal year 2011, the State is contributing at the rate otherwise required under this Section.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2010 is $702,514,000 and shall be made from the State Pensions Fund and proceeds of bonds sold in fiscal year 2010 pursuant to Section 7.2 of the General Obligation Bond Act, less (i) the pro rata share of bond sale expenses determined by the System's share of total bond proceeds, (ii) any amounts received from the General Revenue Fund in fiscal year 2010, (iii) any reduction in bond proceeds due to the issuance of discounted bonds, if applicable.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2011 is the amount recertified by the System on or before April 1, 2011 pursuant to Section 15-165 and shall be made from the State Pensions Fund and proceeds of bonds sold in fiscal year 2011 pursuant to Section 7.2 of the General Obligation Bond Act, less (i) the pro rata share of bond sale expenses determined by the System's share of total bond proceeds, (ii) any amounts received from the General Revenue Fund in fiscal year 2011, and (iii) any reduction in bond proceeds due to the issuance of discounted bonds, if applicable.

Beginning in State fiscal year 2046, the minimum State contribution for each fiscal year shall be the amount needed to maintain the total assets of the System at 90% of the total actuarial liabilities of the System.

Amounts received by the System pursuant to Section 25 of the Budget Stabilization Act or Section 8.12 of the State Finance Act in any fiscal year do not reduce and do not constitute payment of any portion of the minimum State contribution required under this Article in that fiscal year. Such amounts shall not reduce, and shall not be included in the calculation of, the required State contributions under this Article in any future year until the System has reached a funding ratio of at least 90%. A reference in this Article to the "required State contribution" or any substantially similar term does not include or apply to any amounts payable to the System under Section 25 of the Budget Stabilization Act.

Notwithstanding any other provision of this Section, the required State contribution for State fiscal year 2005 and for fiscal year 2008 and each fiscal year thereafter, as calculated under this Section and certified under Section 15-165, shall not exceed an amount equal to (i) the amount of the required State contribution that would have been calculated under this Section for that fiscal year if the System had not received any payments under subsection (d) of Section 7.2 of the General Obligation Bond Act, minus (ii) the portion of the State's total debt service payments for that fiscal year on the bonds issued in fiscal year 2003 for the purposes of that Section 7.2, as determined and certified by the Comptroller, that is the same as the System's portion of the total moneys distributed under subsection (d) of Section 7.2 of the General Obligation Bond Act. In determining this maximum for State fiscal years 2008 through 2010, however, the amount referred to in item (i) shall be increased, as a percentage of the applicable employee payroll, in equal increments calculated from the sum of the required State contribution for State fiscal year 2007 plus the applicable portion of the State's total debt service payments for fiscal year 2007 on the bonds issued in fiscal year 2003 for the purposes of Section 7.2 of the General Obligation Bond Act, so that, by State fiscal year 2011, the State is contributing at the rate otherwise required under this Section.

(a-2) Beginning in fiscal year 2018, each employer under this Article shall pay to the System a required contribution determined as a percentage of projected payroll and sufficient to produce an annual amount equal to:

(i) for each of fiscal years 2018, 2019, and 2020, the defined benefit normal cost of the defined benefit plan, less the employee contribution, for each employee of that employer who has elected or who is deemed to have elected the benefits under Section 1-161 or who has made the election under subsection (c) of Section 1-161; for fiscal year 2021 and each fiscal year thereafter, the defined benefit normal cost of the defined benefit plan, less the employee contribution, plus 2%, for each employee of that employer who has elected or who is deemed to have elected the benefits under Section 1-161 or who has made the election under subsection (c) of Section 1-161; plus

(ii) the amount required for that fiscal year to amortize any unfunded actuarial accrued liability associated with the present value of liabilities attributable to the employer's account under Section 15-155.2, determined as a level percentage of payroll over a 30-year rolling amortization period.

In determining contributions required under item (i) of this subsection, the System shall determine an aggregate rate for all employers, expressed as a percentage of projected payroll.

In determining the contributions required under item (ii) of this subsection, the amount shall be computed by the System on the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the System that is available at the time of the computation.

The contributions required under this subsection (a-2) shall be paid by an employer concurrently with that employer's payroll payment period. The State, as the actual employer of an employee, shall make the required contributions under this subsection.

As used in this subsection, "academic year" means the 12-month period beginning September 1.

(b) If an employee is paid from trust or federal funds, the employer shall pay to the Board contributions from those funds which are sufficient to cover the accruing normal costs on behalf of the employee. However, universities having employees who are compensated out of local auxiliary funds, income funds, or service enterprise funds are not required to pay such contributions on behalf of those employees. The local auxiliary funds, income funds, and service enterprise funds of universities shall not be considered trust funds for the purpose of this Article, but funds of alumni associations, foundations, and athletic associations which are affiliated with the universities included as employers under this Article and other employers which do not receive State appropriations are considered to be trust funds for the purpose of this Article.

(b-1) The City of Urbana and the City of Champaign shall each make employer contributions to this System for their respective firefighter employees who participate in this System pursuant to subsection (h) of Section 15-107. The rate of contributions to be made by those municipalities shall be determined annually by the Board on the basis of the actuarial assumptions adopted by the Board and the recommendations of the actuary, and shall be expressed as a percentage of salary for each such employee. The Board shall certify the rate to the affected municipalities as soon as may be practical. The employer contributions required under this subsection shall be remitted by the municipality to the System at the same time and in the same manner as employee contributions.

(c) Through State fiscal year 1995: The total employer contribution shall be apportioned among the various funds of the State and other employers, whether trust, federal, or other funds, in accordance with actuarial procedures approved by the Board. State of Illinois contributions for employers receiving State appropriations for personal services shall be payable from appropriations made to the employers or to the System. The contributions for Class I community colleges covering earnings other than those paid from trust and federal funds, shall be payable solely from appropriations to the Illinois Community College Board or the System for employer contributions.

(d) Beginning in State fiscal year 1996, the required State contributions to the System shall be appropriated directly to the System and shall be payable through vouchers issued in accordance with subsection (c) of Section 15-165, except as provided in subsection (g).

(e) The State Comptroller shall draw warrants payable to the System upon proper certification by the System or by the employer in accordance with the appropriation laws and this Code.

(f) Normal costs under this Section means liability for pensions and other benefits which accrues to the System because of the credits earned for service rendered by the participants during the fiscal year and expenses of administering the System, but shall not include the principal of or any redemption premium or interest on any bonds issued by the Board or any expenses incurred or deposits required in connection therewith.

(g) If the amount of a participant's earnings for any academic year used to determine the final rate of earnings, determined on a full-time equivalent basis, exceeds the amount of his or her earnings with the same employer for the previous academic year, determined on a full-time equivalent basis, by more than 6%, the participant's employer shall pay to the System, in addition to all other payments required under this Section and in accordance with guidelines established by the System, the present value of the increase in benefits resulting from the portion of the increase in earnings that is in excess of 6%. This present value shall be computed by the System on the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the System that is available at the time of the computation. The System may require the employer to provide any pertinent information or documentation.

Whenever it determines that a payment is or may be required under this subsection (g), the System shall calculate the amount of the payment and bill the employer for that amount. The bill shall specify the calculations used to determine the amount due. If the employer disputes the amount of the bill, it may, within 30 days after receipt of the bill, apply to the System in writing for a recalculation. The application must specify in detail the grounds of the dispute and, if the employer asserts that the calculation is subject to subsection (h), (h-5), or (i) of this Section, must include an affidavit setting forth and attesting to all facts within the employer's knowledge that are pertinent to the applicability of that subsection. Upon receiving a timely application for recalculation, the System shall review the application and, if appropriate, recalculate the amount due.

The employer contributions required under this subsection (g) may be paid in the form of a lump sum within 90 days after receipt of the bill. If the employer contributions are not paid within 90 days after receipt of the bill, then interest will be charged at a rate equal to the System's annual actuarially assumed rate of return on investment compounded annually from the 91st day after receipt of the bill. Payments must be concluded within 7 ~~3~~ years after the employer's receipt of the bill.

When assessing payment for any amount due under this subsection (g), the System shall include earnings, to the extent not established by a participant under Section 15-113.11 or 15-113.12, that would have been paid to the participant had the participant not taken (i) periods of voluntary or involuntary furlough occurring on or after July 1, 2015 and on or before June 30, 2017 or (ii) periods of voluntary pay reduction in lieu of furlough occurring on or after July 1, 2015 and on or before June 30, 2017. Determining earnings that would have been paid to a participant had the participant not taken periods of voluntary or involuntary furlough or periods of voluntary pay reduction shall be the responsibility of the employer, and shall be reported in a manner prescribed by the System.

This subsection (g) does not apply to (1) Tier 2 hybrid plan members and (2) Tier 2 defined benefit members who first participate under this Article on or after the implementation date of the Optional Hybrid Plan.

(g-1) (Blank).

(h) This subsection (h) applies only to payments made or salary increases given on or after June 1, 2005 but before July 1, 2011. The changes made by Public Act 94-1057 shall not require the System to refund any payments received before July 31, 2006 (the effective date of Public Act 94-1057).

When assessing payment for any amount due under subsection (g), the System shall exclude earnings increases paid to participants under contracts or collective bargaining agreements entered into, amended, or renewed before June 1, 2005.

When assessing payment for any amount due under subsection (g), the System shall exclude earnings increases paid to a participant at a time when the participant is 10 or more years from retirement eligibility under Section 15-135.

When assessing payment for any amount due under subsection (g), the System shall exclude earnings increases resulting from overload work, including a contract for summer teaching, or overtime when the employer has certified to the System, and the System has approved the certification, that: (i) in the case of overloads (A) the overload work is for the sole purpose of academic instruction in excess of the standard number of instruction hours for a full-time employee occurring during the academic year that the overload is paid and (B) the earnings increases are equal to or less than the rate of pay for academic instruction computed using the participant's current salary rate and work schedule; and (ii) in the case of overtime, the overtime was necessary for the educational mission.

When assessing payment for any amount due under subsection (g), the System shall exclude any earnings increase resulting from (i) a promotion for which the employee moves from one classification to a higher classification under the State Universities Civil Service System, (ii) a promotion in academic rank for a tenured or tenure-track faculty position, or (iii) a promotion that the Illinois Community College Board has

recommended in accordance with subsection (k) of this Section. These earnings increases shall be excluded only if the promotion is to a position that has existed and been filled by a member for no less than one complete academic year and the earnings increase as a result of the promotion is an increase that results in an amount no greater than the average salary paid for other similar positions.

(h-5) When assessing payment for any amount due under subsection (g), the System shall exclude any earnings increase paid in an academic year beginning on or after July 1, 2020 resulting from overload work performed in an academic year subsequent to an academic year in which the employer was unable to offer or allow to be conducted overload work due to an emergency declaration limiting such activities.

(i) When assessing payment for any amount due under subsection (g), the System shall exclude any salary increase described in subsection (h) of this Section given on or after July 1, 2011 but before July 1, 2014 under a contract or collective bargaining agreement entered into, amended, or renewed on or after June 1, 2005 but before July 1, 2011. Except as provided in subsection (h-5), any payments made or salary increases given after June 30, 2014 shall be used in assessing payment for any amount due under subsection (g) of this Section.

(j) The System shall prepare a report and file copies of the report with the Governor and the General Assembly by January 1, 2007 that contains all of the following information:

(1) The number of recalculations required by the changes made to this Section by Public Act 94-1057 for each employer.

(2) The dollar amount by which each employer's contribution to the System was changed due to recalculations required by Public Act 94-1057.

(3) The total amount the System received from each employer as a result of the changes made to this Section by Public Act 94-4.

(4) The increase in the required State contribution resulting from the changes made to this Section by Public Act 94-1057.

(j-5) For State fiscal years beginning on or after July 1, 2017, if the amount of a participant's earnings for any State fiscal year exceeds the amount of the salary set by law for the Governor that is in effect on July 1 of that fiscal year, the participant's employer shall pay to the System, in addition to all other payments required under this Section and in accordance with guidelines established by the System, an amount determined by the System to be equal to the employer normal cost, as established by the System and expressed as a total percentage of payroll, multiplied by the amount of earnings in excess of the amount of the salary set by law for the Governor. This amount shall be computed by the System on the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the System that is available at the time of the computation. The System may require the employer to provide any pertinent information or documentation.

Whenever it determines that a payment is or may be required under this subsection, the System shall calculate the amount of the payment and bill the employer for that amount. The bill shall specify the calculation used to determine the amount due. If the employer disputes the amount of the bill, it may, within 30 days after receipt of the bill, apply to the System in writing for a recalculation. The application must specify in detail the grounds of the dispute. Upon receiving a timely application for recalculation, the System shall review the application and, if appropriate, recalculate the amount due.

The employer contributions required under this subsection may be paid in the form of a lump sum within 90 days after issuance of the bill. If the employer contributions are not paid within 90 days after issuance of the bill, then interest will be charged at a rate equal to the System's annual actuarially assumed rate of return on investment compounded annually from the 91st day after issuance of the bill. All payments must be received within 3 years after issuance of the bill. If the employer fails to make complete payment, including applicable interest, within 3 years, then the System may, after giving notice to the employer, certify the delinquent amount to the State Comptroller, and the Comptroller shall thereupon deduct the certified delinquent amount from State funds payable to the employer and pay them instead to the System.

This subsection (j-5) does not apply to a participant's earnings to the extent an employer pays the employer normal cost of such earnings.

The changes made to this subsection (j-5) by Public Act 100-624 are intended to apply retroactively to July 6, 2017 (the effective date of Public Act 100-23).

(k) The Illinois Community College Board shall adopt rules for recommending lists of promotional positions submitted to the Board by community colleges and for reviewing the promotional lists on an annual basis. When recommending promotional lists, the Board shall consider the similarity of the positions submitted to those positions recognized for State universities by the State Universities Civil Service System.

The Illinois Community College Board shall file a copy of its findings with the System. The System shall consider the findings of the Illinois Community College Board when making determinations under this Section. The System shall not exclude any earnings increases resulting from a promotion when the promotion was not submitted by a community college. Nothing in this subsection (k) shall require any community college to submit any information to the Community College Board.

(l) For purposes of determining the required State contribution to the System, the value of the System's assets shall be equal to the actuarial value of the System's assets, which shall be calculated as follows:

As of June 30, 2008, the actuarial value of the System's assets shall be equal to the market value of the assets as of that date. In determining the actuarial value of the System's assets for fiscal years after June 30, 2008, any actuarial gains or losses from investment return incurred in a fiscal year shall be recognized in equal annual amounts over the 5-year period following that fiscal year.

(m) For purposes of determining the required State contribution to the system for a particular year, the actuarial value of assets shall be assumed to earn a rate of return equal to the system's actuarially assumed rate of return.

(Source: P.A. 101-10, eff. 6-5-19; 101-81, eff. 7-12-19; 102-16, eff. 6-17-21; 102-558, eff. 8-20-21; 102-764, eff. 5-13-22.)

(40 ILCS 5/16-158) (from Ch. 108 1/2, par. 16-158)

Sec. 16-158. Contributions by State and other employing units.

(a) The State shall make contributions to the System by means of appropriations from the Common School Fund and other State funds of amounts which, together with other employer contributions, employee contributions, investment income, and other income, will be sufficient to meet the cost of maintaining and administering the System on a 90% funded basis in accordance with actuarial recommendations.

The Board shall determine the amount of State contributions required for each fiscal year on the basis of the actuarial tables and other assumptions adopted by the Board and the recommendations of the actuary, using the formula in subsection (b-3).

(a-1) Annually, on or before November 15 until November 15, 2011, the Board shall certify to the Governor the amount of the required State contribution for the coming fiscal year. The certification under this subsection (a-1) shall include a copy of the actuarial recommendations upon which it is based and shall specifically identify the System's projected State normal cost for that fiscal year.

On or before May 1, 2004, the Board shall recalculate and recertify to the Governor the amount of the required State contribution to the System for State fiscal year 2005, taking into account the amounts appropriated to and received by the System under subsection (d) of Section 7.2 of the General Obligation Bond Act.

On or before July 1, 2005, the Board shall recalculate and recertify to the Governor the amount of the required State contribution to the System for State fiscal year 2006, taking into account the changes in required State contributions made by Public Act 94-4.

On or before April 1, 2011, the Board shall recalculate and recertify to the Governor the amount of the required State contribution to the System for State fiscal year 2011, applying the changes made by Public Act 96-889 to the System's assets and liabilities as of June 30, 2009 as though Public Act 96-889 was approved on that date.

(a-5) On or before November 1 of each year, beginning November 1, 2012, the Board shall submit to the State Actuary, the Governor, and the General Assembly a proposed certification of the amount of the required State contribution to the System for the next fiscal year, along with all of the actuarial assumptions, calculations, and data upon which that proposed certification is based. On or before January 1 of each year, beginning January 1, 2013, the State Actuary shall issue a preliminary report concerning the proposed certification and identifying, if necessary, recommended changes in actuarial assumptions that the Board must consider before finalizing its certification of the required State contributions. On or before January 15, 2013 and each January 15 thereafter, the Board shall certify to the Governor and the General Assembly the amount of the required State contribution for the next fiscal year. The Board's certification must note any deviations from the State Actuary's recommended changes, the reason or reasons for not following the State Actuary's recommended changes, and the fiscal impact of not following the State Actuary's recommended changes on the required State contribution.

(a-10) By November 1, 2017, the Board shall recalculate and recertify to the State Actuary, the Governor, and the General Assembly the amount of the State contribution to the System for State fiscal year 2018, taking into account the changes in required State contributions made by Public Act 100-23. The State

Actuary shall review the assumptions and valuations underlying the Board's revised certification and issue a preliminary report concerning the proposed recertification and identifying, if necessary, recommended changes in actuarial assumptions that the Board must consider before finalizing its certification of the required State contributions. The Board's final certification must note any deviations from the State Actuary's recommended changes, the reason or reasons for not following the State Actuary's recommended changes, and the fiscal impact of not following the State Actuary's recommended changes on the required State contribution.

(a-15) On or after June 15, 2019, but no later than June 30, 2019, the Board shall recalculate and recertify to the Governor and the General Assembly the amount of the State contribution to the System for State fiscal year 2019, taking into account the changes in required State contributions made by Public Act 100-587. The recalculation shall be made using assumptions adopted by the Board for the original fiscal year 2019 certification. The monthly voucher for the 12th month of fiscal year 2019 shall be paid by the Comptroller after the recertification required pursuant to this subsection is submitted to the Governor, Comptroller, and General Assembly. The recertification submitted to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct.

(b) Through State fiscal year 1995, the State contributions shall be paid to the System in accordance with Section 18-7 of the School Code.

(b-1) Unless otherwise directed by the Comptroller under subsection (b-1.1), the Board shall submit vouchers for payment of State contributions to the System for the applicable month on the 15th day of each month, or as soon thereafter as may be practicable. The amount vouchered for a monthly payment shall total one-twelfth of the required annual State contribution certified under subsection (a-1).

(b-1.1) Beginning in State fiscal year 2025, if the Comptroller requests that the Board submit, during a State fiscal year, vouchers for multiple monthly payments for the advance payment of State contributions due to the System for that State fiscal year, then the Board shall submit those additional vouchers as directed by the Comptroller, notwithstanding subsection (b-1). Unless an act of appropriations provides otherwise, nothing in this Section authorizes the Board to submit, in a State fiscal year, vouchers for the payment of State contributions to the System in an amount that exceeds the rate of payroll that is certified by the System under this Section for that State fiscal year.

(b-1.2) The vouchers described in subsections (b-1) and (b-1.1) shall be paid by the State Comptroller and Treasurer by warrants drawn on the funds appropriated to the System for that fiscal year.

If in any month the amount remaining unexpended from all other appropriations to the System for the applicable fiscal year (including the appropriations to the System under Section 8.12 of the State Finance Act and Section 1 of the State Pension Funds Continuing Appropriation Act) is less than the amount lawfully vouchered under this subsection, the difference shall be paid from the Common School Fund under the continuing appropriation authority provided in Section 1.1 of the State Pension Funds Continuing Appropriation Act.

(b-2) Allocations from the Common School Fund apportioned to school districts not coming under this System shall not be diminished or affected by the provisions of this Article.

(b-3) For State fiscal years 2012 through 2045, the minimum contribution to the System to be made by the State for each fiscal year shall be an amount determined by the System to be sufficient to bring the total assets of the System up to 90% of the total actuarial liabilities of the System by the end of State fiscal year 2045. In making these determinations, the required State contribution shall be calculated each year as a level percentage of payroll over the years remaining to and including fiscal year 2045 and shall be determined under the projected unit credit actuarial cost method.

For each of State fiscal years 2018, 2019, and 2020, the State shall make an additional contribution to the System equal to 2% of the total payroll of each employee who is deemed to have elected the benefits under Section 1-161 or who has made the election under subsection (c) of Section 1-161.

A change in an actuarial or investment assumption that increases or decreases the required State contribution and first applies in State fiscal year 2018 or thereafter shall be implemented in equal annual amounts over a 5-year period beginning in the State fiscal year in which the actuarial change first applies to the required State contribution.

A change in an actuarial or investment assumption that increases or decreases the required State contribution and first applied to the State contribution in fiscal year 2014, 2015, 2016, or 2017 shall be implemented:

(i) as already applied in State fiscal years before 2018; and

(ii) in the portion of the 5-year period beginning in the State fiscal year in which the actuarial change first applied that occurs in State fiscal year 2018 or thereafter, by calculating the change in equal annual amounts over that 5-year period and then implementing it at the resulting annual rate in each of the remaining fiscal years in that 5-year period.

For State fiscal years 1996 through 2005, the State contribution to the System, as a percentage of the applicable employee payroll, shall be increased in equal annual increments so that by State fiscal year 2011, the State is contributing at the rate required under this Section; except that in the following specified State fiscal years, the State contribution to the System shall not be less than the following indicated percentages of the applicable employee payroll, even if the indicated percentage will produce a State contribution in excess of the amount otherwise required under this subsection and subsection (a), and notwithstanding any contrary certification made under subsection (a-1) before May 27, 1998 (the effective date of Public Act 90-582): 10.02% in FY 1999; 10.77% in FY 2000; 11.47% in FY 2001; 12.16% in FY 2002; 12.86% in FY 2003; and 13.56% in FY 2004.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2006 is $534,627,700.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2007 is $738,014,500.

For each of State fiscal years 2008 through 2009, the State contribution to the System, as a percentage of the applicable employee payroll, shall be increased in equal annual increments from the required State contribution for State fiscal year 2007, so that by State fiscal year 2011, the State is contributing at the rate otherwise required under this Section.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2010 is $2,089,268,000 and shall be made from the proceeds of bonds sold in fiscal year 2010 pursuant to Section 7.2 of the General Obligation Bond Act, less (i) the pro rata share of bond sale expenses determined by the System's share of total bond proceeds, (ii) any amounts received from the Common School Fund in fiscal year 2010, and (iii) any reduction in bond proceeds due to the issuance of discounted bonds, if applicable.

Notwithstanding any other provision of this Article, the total required State contribution for State fiscal year 2011 is the amount recertified by the System on or before April 1, 2011 pursuant to subsection (a-1) of this Section and shall be made from the proceeds of bonds sold in fiscal year 2011 pursuant to Section 7.2 of the General Obligation Bond Act, less (i) the pro rata share of bond sale expenses determined by the System's share of total bond proceeds, (ii) any amounts received from the Common School Fund in fiscal year 2011, and (iii) any reduction in bond proceeds due to the issuance of discounted bonds, if applicable. This amount shall include, in addition to the amount certified by the System, an amount necessary to meet employer contributions required by the State as an employer under paragraph (e) of this Section, which may also be used by the System for contributions required by paragraph (a) of Section 16-127.

Beginning in State fiscal year 2046, the minimum State contribution for each fiscal year shall be the amount needed to maintain the total assets of the System at 90% of the total actuarial liabilities of the System.

Amounts received by the System pursuant to Section 25 of the Budget Stabilization Act or Section 8.12 of the State Finance Act in any fiscal year do not reduce and do not constitute payment of any portion of the minimum State contribution required under this Article in that fiscal year. Such amounts shall not reduce, and shall not be included in the calculation of, the required State contributions under this Article in any future year until the System has reached a funding ratio of at least 90%. A reference in this Article to the "required State contribution" or any substantially similar term does not include or apply to any amounts payable to the System under Section 25 of the Budget Stabilization Act.

Notwithstanding any other provision of this Section, the required State contribution for State fiscal year 2005 and for fiscal year 2008 and each fiscal year thereafter, as calculated under this Section and certified under subsection (a-1), shall not exceed an amount equal to (i) the amount of the required State contribution that would have been calculated under this Section for that fiscal year if the System had not received any payments under subsection (d) of Section 7.2 of the General Obligation Bond Act, minus (ii) the portion of the State's total debt service payments for that fiscal year on the bonds issued in fiscal year 2003 for the purposes of that Section 7.2, as determined and certified by the Comptroller, that is the same as the System's portion of the total moneys distributed under subsection (d) of Section 7.2 of the General Obligation Bond Act. In determining this maximum for State fiscal years 2008 through 2010, however, the

amount referred to in item (i) shall be increased, as a percentage of the applicable employee payroll, in equal increments calculated from the sum of the required State contribution for State fiscal year 2007 plus the applicable portion of the State's total debt service payments for fiscal year 2007 on the bonds issued in fiscal year 2003 for the purposes of Section 7.2 of the General Obligation Bond Act, so that, by State fiscal year 2011, the State is contributing at the rate otherwise required under this Section.

(b-4) Beginning in fiscal year 2018, each employer under this Article shall pay to the System a required contribution determined as a percentage of projected payroll and sufficient to produce an annual amount equal to:

(i) for each of fiscal years 2018, 2019, and 2020, the defined benefit normal cost of the defined benefit plan, less the employee contribution, for each employee of that employer who has elected or who is deemed to have elected the benefits under Section 1-161 or who has made the election under subsection (b) of Section 1-161; for fiscal year 2021 and each fiscal year thereafter, the defined benefit normal cost of the defined benefit plan, less the employee contribution, plus 2%, for each employee of that employer who has elected or who is deemed to have elected the benefits under Section 1-161 or who has made the election under subsection (b) of Section 1-161; plus

(ii) the amount required for that fiscal year to amortize any unfunded actuarial accrued liability associated with the present value of liabilities attributable to the employer's account under Section 16-158.3, determined as a level percentage of payroll over a 30-year rolling amortization period.

In determining contributions required under item (i) of this subsection, the System shall determine an aggregate rate for all employers, expressed as a percentage of projected payroll.

In determining the contributions required under item (ii) of this subsection, the amount shall be computed by the System on the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the System that is available at the time of the computation.

The contributions required under this subsection (b-4) shall be paid by an employer concurrently with that employer's payroll payment period. The State, as the actual employer of an employee, shall make the required contributions under this subsection.

(c) Payment of the required State contributions and of all pensions, retirement annuities, death benefits, refunds, and other benefits granted under or assumed by this System, and all expenses in connection with the administration and operation thereof, are obligations of the State.

If members are paid from special trust or federal funds which are administered by the employing unit, whether school district or other unit, the employing unit shall pay to the System from such funds the full accruing retirement costs based upon that service, which, beginning July 1, 2017, shall be at a rate, expressed as a percentage of salary, equal to the total employer's normal cost, expressed as a percentage of payroll, as determined by the System. Employer contributions, based on salary paid to members from federal funds, may be forwarded by the distributing agency of the State of Illinois to the System prior to allocation, in an amount determined in accordance with guidelines established by such agency and the System. Any contribution for fiscal year 2015 collected as a result of the change made by Public Act 98-674 shall be considered a State contribution under subsection (b-3) of this Section.

(d) Effective July 1, 1986, any employer of a teacher as defined in paragraph (8) of Section 16-106 shall pay the employer's normal cost of benefits based upon the teacher's service, in addition to employee contributions, as determined by the System. Such employer contributions shall be forwarded monthly in accordance with guidelines established by the System.

However, with respect to benefits granted under Section 16-133.4 or 16-133.5 to a teacher as defined in paragraph (8) of Section 16-106, the employer's contribution shall be 12% (rather than 20%) of the member's highest annual salary rate for each year of creditable service granted, and the employer shall also pay the required employee contribution on behalf of the teacher. For the purposes of Sections 16-133.4 and 16-133.5, a teacher as defined in paragraph (8) of Section 16-106 who is serving in that capacity while on leave of absence from another employer under this Article shall not be considered an employee of the employer from which the teacher is on leave.

(e) Beginning July 1, 1998, every employer of a teacher shall pay to the System an employer contribution computed as follows:

(1) Beginning July 1, 1998 through June 30, 1999, the employer contribution shall be equal to 0.3% of each teacher's salary.

(2) Beginning July 1, 1999 and thereafter, the employer contribution shall be equal to 0.58% of each teacher's salary.

The school district or other employing unit may pay these employer contributions out of any source of funding available for that purpose and shall forward the contributions to the System on the schedule established for the payment of member contributions.

These employer contributions are intended to offset a portion of the cost to the System of the increases in retirement benefits resulting from Public Act 90-582.

Each employer of teachers is entitled to a credit against the contributions required under this subsection (e) with respect to salaries paid to teachers for the period January 1, 2002 through June 30, 2003, equal to the amount paid by that employer under subsection (a-5) of Section 6.6 of the State Employees Group Insurance Act of 1971 with respect to salaries paid to teachers for that period.

The additional 1% employee contribution required under Section 16-152 by Public Act 90-582 is the responsibility of the teacher and not the teacher's employer, unless the employer agrees, through collective bargaining or otherwise, to make the contribution on behalf of the teacher.

If an employer is required by a contract in effect on May 1, 1998 between the employer and an employee organization to pay, on behalf of all its full-time employees covered by this Article, all mandatory employee contributions required under this Article, then the employer shall be excused from paying the employer contribution required under this subsection (e) for the balance of the term of that contract. The employer and the employee organization shall jointly certify to the System the existence of the contractual requirement, in such form as the System may prescribe. This exclusion shall cease upon the termination, extension, or renewal of the contract at any time after May 1, 1998.

(f) If the amount of a teacher's salary for any school year used to determine final average salary exceeds the member's annual full-time salary rate with the same employer for the previous school year by more than 6%, the teacher's employer shall pay to the System, in addition to all other payments required under this Section and in accordance with guidelines established by the System, the present value of the increase in benefits resulting from the portion of the increase in salary that is in excess of 6%. This present value shall be computed by the System on the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the System that is available at the time of the computation. If a teacher's salary for the 2005-2006 school year is used to determine final average salary under this subsection (f), then the changes made to this subsection (f) by Public Act 94-1057 shall apply in calculating whether the increase in his or her salary is in excess of 6%. For the purposes of this Section, change in employment under Section 10-21.12 of the School Code on or after June 1, 2005 shall constitute a change in employer. The System may require the employer to provide any pertinent information or documentation. The changes made to this subsection (f) by Public Act 94-1111 apply without regard to whether the teacher was in service on or after its effective date.

Whenever it determines that a payment is or may be required under this subsection, the System shall calculate the amount of the payment and bill the employer for that amount. The bill shall specify the calculations used to determine the amount due. If the employer disputes the amount of the bill, it may, within 30 days after receipt of the bill, apply to the System in writing for a recalculation. The application must specify in detail the grounds of the dispute and, if the employer asserts that the calculation is subject to subsection (g), (g-5), (g-10), (g-15), (g-20), or (h) of this Section, must include an affidavit setting forth and attesting to all facts within the employer's knowledge that are pertinent to the applicability of that subsection. Upon receiving a timely application for recalculation, the System shall review the application and, if appropriate, recalculate the amount due.

The employer contributions required under this subsection (f) may be paid in the form of a lump sum within 90 days after receipt of the bill. If the employer contributions are not paid within 90 days after receipt of the bill, then interest will be charged at a rate equal to the System's annual actuarially assumed rate of return on investment compounded annually from the 91st day after receipt of the bill. Payments must be concluded within 7 ~~3~~ years after the employer's receipt of the bill.

(f-1) (Blank).

(g) This subsection (g) applies only to payments made or salary increases given on or after June 1, 2005 but before July 1, 2011. The changes made by Public Act 94-1057 shall not require the System to refund any payments received before July 31, 2006 (the effective date of Public Act 94-1057).

When assessing payment for any amount due under subsection (f), the System shall exclude salary increases paid to teachers under contracts or collective bargaining agreements entered into, amended, or renewed before June 1, 2005.

When assessing payment for any amount due under subsection (f), the System shall exclude salary increases paid to a teacher at a time when the teacher is 10 or more years from retirement eligibility under Section 16-132 or 16-133.2.

When assessing payment for any amount due under subsection (f), the System shall exclude salary increases resulting from overload work, including summer school, when the school district has certified to the System, and the System has approved the certification, that (i) the overload work is for the sole purpose of classroom instruction in excess of the standard number of classes for a full-time teacher in a school district during a school year and (ii) the salary increases are equal to or less than the rate of pay for classroom instruction computed on the teacher's current salary and work schedule.

When assessing payment for any amount due under subsection (f), the System shall exclude a salary increase resulting from a promotion (i) for which the employee is required to hold a certificate or supervisory endorsement issued by the State Teacher Certification Board that is a different certification or supervisory endorsement than is required for the teacher's previous position and (ii) to a position that has existed and been filled by a member for no less than one complete academic year and the salary increase from the promotion is an increase that results in an amount no greater than the lesser of the average salary paid for other similar positions in the district requiring the same certification or the amount stipulated in the collective bargaining agreement for a similar position requiring the same certification.

When assessing payment for any amount due under subsection (f), the System shall exclude any payment to the teacher from the State of Illinois or the State Board of Education over which the employer does not have discretion, notwithstanding that the payment is included in the computation of final average salary.

(g-5) When assessing payment for any amount due under subsection (f), the System shall exclude salary increases resulting from overload or stipend work performed in a school year subsequent to a school year in which the employer was unable to offer or allow to be conducted overload or stipend work due to an emergency declaration limiting such activities.

(g-10) When assessing payment for any amount due under subsection (f), the System shall exclude salary increases resulting from increased instructional time that exceeded the instructional time required during the 2019-2020 school year.

(g-15) When assessing payment for any amount due under subsection (f), the System shall exclude salary increases resulting from teaching summer school on or after May 1, 2021 and before September 15, 2022.

(g-20) When assessing payment for any amount due under subsection (f), the System shall exclude salary increases necessary to bring a school board in compliance with Public Act 101-443 or this amendatory Act of the 103rd General Assembly.

(h) When assessing payment for any amount due under subsection (f), the System shall exclude any salary increase described in subsection (g) of this Section given on or after July 1, 2011 but before July 1, 2014 under a contract or collective bargaining agreement entered into, amended, or renewed on or after June 1, 2005 but before July 1, 2011. Notwithstanding any other provision of this Section, any payments made or salary increases given after June 30, 2014 shall be used in assessing payment for any amount due under subsection (f) of this Section.

(i) The System shall prepare a report and file copies of the report with the Governor and the General Assembly by January 1, 2007 that contains all of the following information:

(1) The number of recalculations required by the changes made to this Section by Public Act 94-1057 for each employer.

(2) The dollar amount by which each employer's contribution to the System was changed due to recalculations required by Public Act 94-1057.

(3) The total amount the System received from each employer as a result of the changes made to this Section by Public Act 94-4.

(4) The increase in the required State contribution resulting from the changes made to this Section by Public Act 94-1057.

(i-5) For school years beginning on or after July 1, 2017, if the amount of a participant's salary for any school year exceeds the amount of the salary set for the Governor, the participant's employer shall pay to the System, in addition to all other payments required under this Section and in accordance with guidelines established by the System, an amount determined by the System to be equal to the employer normal cost, as established by the System and expressed as a total percentage of payroll, multiplied by the amount of salary in excess of the amount of the salary set for the Governor. This amount shall be computed by the System on

the basis of the actuarial assumptions and tables used in the most recent actuarial valuation of the System that is available at the time of the computation. The System may require the employer to provide any pertinent information or documentation.

Whenever it determines that a payment is or may be required under this subsection, the System shall calculate the amount of the payment and bill the employer for that amount. The bill shall specify the calculations used to determine the amount due. If the employer disputes the amount of the bill, it may, within 30 days after receipt of the bill, apply to the System in writing for a recalculation. The application must specify in detail the grounds of the dispute. Upon receiving a timely application for recalculation, the System shall review the application and, if appropriate, recalculate the amount due.

The employer contributions required under this subsection may be paid in the form of a lump sum within 90 days after receipt of the bill. If the employer contributions are not paid within 90 days after receipt of the bill, then interest will be charged at a rate equal to the System's annual actuarially assumed rate of return on investment compounded annually from the 91st day after receipt of the bill. Payments must be concluded within 3 years after the employer's receipt of the bill.

(j) For purposes of determining the required State contribution to the System, the value of the System's assets shall be equal to the actuarial value of the System's assets, which shall be calculated as follows:

As of June 30, 2008, the actuarial value of the System's assets shall be equal to the market value of the assets as of that date. In determining the actuarial value of the System's assets for fiscal years after June 30, 2008, any actuarial gains or losses from investment return incurred in a fiscal year shall be recognized in equal annual amounts over the 5-year period following that fiscal year.

(k) For purposes of determining the required State contribution to the system for a particular year, the actuarial value of assets shall be assumed to earn a rate of return equal to the system's actuarially assumed rate of return.

(Source: P.A. 102-16, eff. 6-17-21; 102-525, eff. 8-20-21; 102-558, eff. 8-20-21; 102-813, eff. 5-13-22; 103-515, eff. 8-11-23; 103-588, eff. 6-5-24.)

Article 19.

Section 19-5. The Illinois Pension Code is amended by changing Section 7-217 as follows:

(40 ILCS 5/7-217) (from Ch. 108 1/2, par. 7-217)

Sec. 7-217. Payment of benefits and assignments.

(a) Except as otherwise provided in this Section, all moneys in the Fund created by this Article, and all securities and other property of the Fund, and all annuities and other benefits payable under this Article, and all accumulated contributions and other credits of employees in this Fund, and the right of any person to receive an annuity or other benefit under this Article, or a refund or return of contributions, shall not be subject to judgment, execution, garnishment, attachment, or other seizure by process, in bankruptcy or otherwise, nor to sale, pledge, mortgage or other alienation, and shall not be assignable. Notwithstanding Section 1-103.1, the changes in this Section made by this amendatory Act of 1991 shall not be limited to persons in service on or after its effective date. All annuities and other benefits payable under this Fund and all accumulated credits of employees in the Fund shall be exempt from state and municipal taxes.

(b) The board, in its discretion, may:

1. Pay to the wife of any annuitant or employee such portion, or all, of any retirement annuity, disability benefit, or separation benefit payable to an annuitant or employee, in the event of the disappearance or unexplained absence, or the failure to support such wife or children, as the board may consider necessary for the support of the wife or children of the annuitant or employee.

2. Where a temporary or total and permanent disability benefit becomes payable and the amount may be reduced by application of Section 7-148(b) or Section 7-152(b), postpone making the reduction, if there is a delay in the determination whether a disability benefit is payable under the Federal Social Security Act, until the determination has been made. The Board may retain out of any annuity or benefit to the participating employee or to any person taking through him the amount of any payment which is not reduced by reason of this paragraph.

3. Pay amounts payable to a minor or person under legal disability to a representative payee assuming responsibility for such minor or person under legal disability, waiving guardianship.

(c) The board may retain out of any annuity or benefit payable to any person such amount or amounts as the board may determine are owing to the fund because required employee contributions were not made,

in whole or in part, or employee obligations to return refunds were not made, or because money was paid to any annuitant or employee through misrepresentation, fraud or error.

(d) The board and the fund shall be held free from any liability for any money retained or paid in accordance with this section and the employee shall be assumed to have assented and agreed to any such disposition of money due.

(e) An annuitant entitled to receive an annuity may, for personal reasons and without disclosure thereof, request the board in writing to suspend for any period payment of all or any part of such annuity otherwise payable hereunder. The board, on receipt of such request, shall authorize such suspension, in which event the annuitant shall be deemed to have forfeited all rights to the amount of annuity so suspended, but shall retain the right to have full annuity otherwise payable reinstated as to future monthly payments upon written notice to the board of his desire to revoke his prior request for a suspension under this paragraph.

(f) The board may reimburse any municipality or participating instrumentality for employee contributions due such municipality or participating instrumentality, from funds withheld by the board pursuant to this Section.

(g) An annuitant may authorize the withholding of a portion of his annuity for payment ~~of dues~~ to any labor organization designated by the annuitant; however, no portion of annuities may be withheld pursuant to this subsection for payment to any one labor organization unless a minimum of 100 annuitants authorize such withholding, except that the Board may allow such withholding for less than 100 annuitants during a probationary period of between 3 and 6 months, as determined by the Board. The Board shall prescribe a form for the authorization of such withholding, and shall provide such forms to employees, annuitants and labor organizations upon request. Amounts withheld by the Board under this subsection shall be promptly paid over to the designated organizations.

(Source: P.A. 87-740.)

Article 23.

Section 23-5. The Illinois Pension Code is amended by changing Section 16-127 as follows:

(40 ILCS 5/16-127) (from Ch. 108 1/2, par. 16-127)

Sec. 16-127. Computation of creditable service.

(a) Each member shall receive regular credit for all service as a teacher from the date membership begins, for which satisfactory evidence is supplied and all contributions have been paid.

(b) The following periods of service shall earn optional credit and each member shall receive credit for all such service for which satisfactory evidence is supplied and all contributions have been paid as of the date specified:

(1) Prior service as a teacher.

(2) Service in a capacity essentially similar or equivalent to that of a teacher, in the public common schools in school districts in this State not included within the provisions of this System, or of any other State, territory, dependency or possession of the United States, or in schools operated by or under the auspices of the United States, or under the auspices of any agency or department of any other State, and service during any period of professional speech correction or special education experience for a public agency within this State or any other State, territory, dependency or possession of the United States, and service prior to February 1, 1951 as a recreation worker for the Illinois Department of Public Safety, for a period not exceeding the lesser of 2/5 of the total creditable service of the member or 10 years. The maximum service of 10 years which is allowable under this paragraph shall be reduced by the service credit which is validated by other retirement systems under paragraph (i) of Section 15-113 and paragraph 1 of Section 17-133. Credit granted under this paragraph may not be used in determination of a retirement annuity or disability benefits unless the member has at least 5 years of creditable service earned subsequent to this employment with one or more of the following systems: Teachers' Retirement System of the State of Illinois, State Universities Retirement System, and the Public School Teachers' Pension and Retirement Fund of Chicago. Whenever such service credit exceeds the maximum allowed for all purposes of this Article, the first service rendered in point of time shall be considered. The changes to this paragraph (2) made by Public Act 86-272 shall apply not only to persons who on or after its effective date (August 23, 1989) are in service as a teacher under the System, but also to persons whose status as such a teacher terminated prior to such effective date, whether or not such person is an annuitant on that date.

(3) Any periods immediately following teaching service, under this System or under Article 17, (or immediately following service prior to February 1, 1951 as a recreation worker for the Illinois Department of Public Safety) spent in active service with the military forces of the United States; periods spent in educational programs that prepare for return to teaching sponsored by the federal government following such active military service; if a teacher returns to teaching service within one calendar year after discharge or after the completion of the educational program, a further period, not exceeding one calendar year, between time spent in military service or in such educational programs and the return to employment as a teacher under this System; and a period of up to 2 years of active military service not immediately following employment as a teacher.

The changes to this Section and Section 16-128 relating to military service made by Public Act 87-794 shall apply not only to persons who on or after its effective date are in service as a teacher under the System, but also to persons whose status as a teacher terminated prior to that date, whether or not the person is an annuitant on that date. In the case of an annuitant who applies for credit allowable under this Section for a period of military service that did not immediately follow employment, and who has made the required contributions for such credit, the annuity shall be recalculated to include the additional service credit, with the increase taking effect on the date the System received written notification of the annuitant's intent to purchase the credit, if payment of all the required contributions is made within 60 days of such notice, or else on the first annuity payment date following the date of payment of the required contributions. In calculating the automatic annual increase for an annuity that has been recalculated under this Section, the increase attributable to the additional service allowable under Public Act 87-794 shall be included in the calculation of automatic annual increases accruing after the effective date of the recalculation.

Credit for military service shall be determined as follows: if entry occurs during the months of July, August, or September and the member was a teacher at the end of the immediately preceding school term, credit shall be granted from July 1 of the year in which he or she entered service; if entry occurs during the school term and the teacher was in teaching service at the beginning of the school term, credit shall be granted from July 1 of such year. In all other cases where credit for military service is allowed, credit shall be granted from the date of entry into the service.

The total period of military service for which credit is granted shall not exceed 5 years for any member unless the service: (A) is validated before July 1, 1964, and (B) does not extend beyond July 1, 1963. Credit for military service shall be granted under this Section only if not more than 5 years of the military service for which credit is granted under this Section is used by the member to qualify for a military retirement allotment from any branch of the armed forces of the United States. The changes to this paragraph (3) made by Public Act 86-272 shall apply not only to persons who on or after its effective date (August 23, 1989) are in service as a teacher under the System, but also to persons whose status as such a teacher terminated prior to such effective date, whether or not such person is an annuitant on that date.

(4) Any periods served as a member of the General Assembly.

(5)(i) Any periods for which a teacher, as defined in Section 16-106, is granted a leave of absence, provided he or she returns to teaching service creditable under this System or the State Universities Retirement System following the leave; (ii) periods during which a teacher is involuntarily laid off from teaching, provided he or she returns to teaching following the lay-off; (iii) periods prior to July 1, 1983 during which a teacher ceased covered employment due to pregnancy, provided that the teacher returned to teaching service creditable under this System or the State Universities Retirement System following the pregnancy and submits evidence satisfactory to the Board documenting that the employment ceased due to pregnancy; and (iv) periods prior to July 1, 1983 during which a teacher ceased covered employment for the purpose of adopting an infant under 3 years of age or caring for a newly adopted infant under 3 years of age, provided that the teacher returned to teaching service creditable under this System or the State Universities Retirement System following the adoption and submits evidence satisfactory to the Board documenting that the employment ceased for the purpose of adopting an infant under 3 years of age or caring for a newly adopted infant under 3 years of age. However, total credit under this paragraph (5) may not exceed 3 years.

Any qualified member or annuitant may apply for credit under item (iii) or (iv) of this paragraph (5) without regard to whether service was terminated before June 27, 1997 (the effective date of Public Act 90-32). In the case of an annuitant who establishes credit under item (iii) or (iv),

the annuity shall be recalculated to include the additional service credit. The increase in annuity shall take effect on the date the System receives written notification of the annuitant's intent to purchase the credit, if the required evidence is submitted and the required contribution paid within 60 days of that notification, otherwise on the first annuity payment date following the System's receipt of the required evidence and contribution. The increase in an annuity recalculated under this provision shall be included in the calculation of automatic annual increases in the annuity accruing after the effective date of the recalculation.

Optional credit may be purchased under this paragraph (5) for periods during which a teacher has been granted a leave of absence pursuant to Section 24-13 of the School Code. A teacher whose service under this Article terminated prior to the effective date of Public Act 86-1488 shall be eligible to purchase such optional credit. If a teacher who purchases this optional credit is already receiving a retirement annuity under this Article, the annuity shall be recalculated as if the annuitant had applied for the leave of absence credit at the time of retirement. The difference between the entitled annuity and the actual annuity shall be credited to the purchase of the optional credit. The remainder of the purchase cost of the optional credit shall be paid on or before April 1, 1992.

The change in this paragraph made by Public Act 86-273 shall be applicable to teachers who retire after June 1, 1989, as well as to teachers who are in service on that date.

(6) Any days of unused and uncompensated accumulated sick leave earned by a teacher. The service credit granted under this paragraph shall be the ratio of the number of unused and uncompensated accumulated sick leave days to 170 days, subject to a maximum of 2 years of service credit. Prior to the member's retirement, each former employer shall certify to the System the number of unused and uncompensated accumulated sick leave days credited to the member at the time of termination of service. The period of unused sick leave shall not be considered in determining the effective date of retirement. A member is not required to make contributions in order to obtain service credit for unused sick leave.

Credit for sick leave shall, at retirement, be granted by the System for any retiring regional or assistant regional superintendent of schools at the rate of 6 days per year of creditable service or portion thereof established while serving as such superintendent or assistant superintendent.

(7) Periods prior to February 1, 1987 served as an employee of the Illinois Mathematics and Science Academy for which credit has not been terminated under Section 15-113.9 of this Code.

(8) Service as a substitute teacher for work performed prior to July 1, 1990.

(9) Service as a part-time teacher for work performed prior to July 1, 1990.

(10) Up to 2 years of employment with Southern Illinois University - Carbondale from September 1, 1959 to August 31, 1961, or with Governors State University from September 1, 1972 to August 31, 1974, for which the teacher has no credit under Article 15. To receive credit under this item (10), a teacher must apply in writing to the Board and pay the required contributions before May 1, 1993 and have at least 12 years of service credit under this Article.

(11) Periods of service as a student teacher as described in Section 24-8.5 of the School Code for which the student teacher received a salary.

(b-1) A member may establish optional credit for up to 2 years of service as a teacher or administrator employed by a private school recognized by the Illinois State Board of Education, provided that the teacher (i) was certified under the law governing the certification of teachers at the time the service was rendered, (ii) applies in writing on or before June 30, 2028, (iii) supplies satisfactory evidence of the employment, (iv) completes at least 10 years of contributing service as a teacher as defined in Section 16-106, and (v) pays the contribution required in subsection (d-5) of Section 16-128. The member may apply for credit under this subsection and pay the required contribution before completing the 10 years of contributing service required under item (iv), but the credit may not be used until the item (iv) contributing service requirement has been met.

(b-2) A member may establish optional credit for up to 2 years of service as a career and technical educator, including, but not limited to, a career and technical education teacher, for which credit is not held in any other public employee pension fund or retirement system if the member (i) was certified or licensed under the law governing the certification or licensure of teachers at the time the service was rendered, (ii) applies in writing on or before June 30, 2028, (iii) supplies satisfactory evidence of the employment, (iv) completes at least 10 years of contributing service as a teacher as defined in Section 16-106, and (v) pays the contribution required in subsection (d-5) of Section 16-128. The member may apply for credit under this subsection and pay the required contribution before completing the 10 years of contributing service required

under item (iv), but the credit may not be used until the item (iv) contributing service requirement has been met.

(c) The service credits specified in this Section shall be granted only if: (1) such service credits are not used for credit in any other statutory tax-supported public employee retirement system other than the federal Social Security program; and (2) the member makes the required contributions as specified in Section 16-128. Except as provided in subsection (b-1) of this Section, the service credit shall be effective as of the date the required contributions are completed.

Any service credits granted under this Section shall terminate upon cessation of membership for any cause.

Credit may not be granted under this Section covering any period for which an age retirement or disability retirement allowance has been paid.

Credit may not be granted under this Section for service as an employee of an entity that provides substitute teaching services under Section 2-3.173 of the School Code and is not a school district.
(Source: P.A. 102-525, eff. 8-20-21; 103-17, eff. 6-9-23; 103-525, eff. 8-11-23; 103-605, eff. 7-1-24.)

Article 26.

Section 26-5. The Illinois Pension Code is amended by changing Sections 3-110.12 and 4-108 as follows:

(40 ILCS 5/3-110.12)

Sec. 3-110.12. Transfer to Article 4 fund.

(a) At any time during the 6 months following the effective date of this Section, an active member of an Article 4 firefighters' pension fund may apply for transfer to that fund of up to 6 years of his or her creditable service accumulated in the police pension fund under this Article that is administered by the same unit of local government if that active member was not subject to disciplinary action when he or she terminated employment with that police department. The creditable service shall be transferred upon payment by the police pension fund to the Article 4 fund of an amount equal to:

(1) the amounts accumulated to the credit of the applicant on the books of the fund on the date of transfer for the service to be transferred; and

(2) employer contributions in an amount equal to the amount determined under item (1); and

(3) any interest paid by the applicant in order to reinstate service.

Participation in the police pension fund with respect to the transferred creditable service shall terminate on the date of transfer.

(a-5) At any time during the 6 months following the effective date of this amendatory Act of the 102nd General Assembly, an active member of an Article 4 firefighters' pension fund may apply for transfer to that fund of up to 8 years of his or her creditable service accumulated in a police pension fund under this Article that is administered by a unit of local government if that active member was not subject to disciplinary action when he or she terminated employment with that police department. The creditable service shall be transferred upon payment by the police pension fund to the Article 4 fund of an amount equal to:

(1) the amounts accumulated to the credit of the applicant on the books of the fund on the date of transfer for the service to be transferred; and

(2) employer contributions in an amount equal to the amount determined under item (1); and

(3) any interest paid by the applicant in order to reinstate service.

Participation in the police pension fund with respect to the transferred creditable service shall terminate on the date of transfer.

(a-10) At any time during the 6 months following the effective date of this amendatory Act of the 104th General Assembly, an active member of an Article 4 firefighters' pension fund may apply for transfer to that fund of up to 8 years of his or her creditable service accumulated in a police pension fund under this Article that is administered by a unit of local government if that active member was not subject to disciplinary action when he or she terminated employment with that police department. The creditable service shall be transferred upon payment by the police pension fund to the Article 4 fund of an amount equal to:

(1) the amounts accumulated to the credit of the applicant on the books of the fund on the date of transfer for the service to be transferred; and

(2) employer contributions in an amount equal to the amount determined under item (1); and

(3) any interest paid by the applicant in order to reinstate service.

Participation in the police pension fund with respect to the transferred creditable service shall terminate on the date of transfer.

(b) At the time of applying for transfer of creditable service under this Section, an active member of an Article 4 firefighters' pension fund may, for the purpose of that transfer, reinstate creditable service that was terminated by receipt of a refund, by payment to the police pension fund of the amount of the refund with interest thereon at the rate of 6% per year, compounded annually, from the date of the refund to the date of payment.

(Source: P.A. 102-63, eff. 7-9-21.)

(40 ILCS 5/4-108) (from Ch. 108 1/2, par. 4-108)

Sec. 4-108. Creditable service.

(a) Creditable service is the time served as a firefighter of a municipality. In computing creditable service, furloughs and leaves of absence without pay exceeding 30 days in any one year shall not be counted, but leaves of absence for illness or accident regardless of length, and periods of disability for which a firefighter received no disability pension payments under this Article, shall be counted.

(b) Furloughs and leaves of absence of 30 days or less in any one year may be counted as creditable service, if the firefighter makes the contribution to the fund that would have been required had he or she not been on furlough or leave of absence. To qualify for this creditable service, the firefighter must pay the required contributions to the fund not more than 90 days subsequent to the termination of the furlough or leave of absence, to the extent that the municipality has not made such contribution on his or her behalf.

(c) Creditable service includes:

(1) Service in the military, naval or air forces of the United States entered upon when the person was an active firefighter, provided that, upon applying for a permanent pension, and in accordance with the rules of the board the firefighter pays into the fund the amount that would have been contributed had he or she been a regular contributor during such period of service, if and to the extent that the municipality which the firefighter served made no such contributions in his or her behalf. The total amount of such creditable service shall not exceed 5 years, except that any firefighter who on July 1, 1973 had more than 5 years of such creditable service shall receive the total amount thereof as of that date.

(1.5) Up to 24 months of service in the military, naval, or air forces of the United States that was served prior to employment by a municipality or fire protection district as a firefighter. To receive the credit for the military service prior to the employment as a firefighter, the firefighter must apply in writing to the fund and must make contributions to the fund equal to (i) the employee contributions that would have been required had the service been rendered as a member, plus (ii) an amount determined by the fund to be equal to the employer's normal cost of the benefits accrued for that military service, plus (iii) interest at the actuarially assumed rate provided by the Public Pension Division of the Department of Insurance, compounded annually from the first date of membership in the fund to the date of payment on items (i) and (ii). The changes to this paragraph (1.5) by this amendatory Act of the 95th General Assembly apply only to participating employees in service on or after its effective date.

(2) Service prior to July 1, 1976 by a firefighter initially excluded from participation by reason of age who elected to participate and paid the required contributions for such service.

(3) Up to 8 years of service by a firefighter as an officer in a statewide firefighters' association when he is on a leave of absence from a municipality's payroll, provided that (i) the firefighter has at least 10 years of creditable service as an active firefighter, (ii) the firefighter contributes to the fund the amount that he would have contributed had he remained an active member of the fund, (iii) the employee or statewide firefighter association contributes to the fund an amount equal to the employer's required contribution as determined by the board, and (iv) for all leaves of absence under this subdivision (3), including those beginning before the effective date of this amendatory Act of the 97th General Assembly, the firefighter continues to remain in sworn status, subject to the professional standards of the public employer or those terms established in statute.

(4) Time spent as an on-call fireman for a municipality, calculated at the rate of one year of creditable service for each 5 years of time spent as an on-call fireman, provided that (i) the firefighter has at least 18 years of creditable service as an active firefighter, (ii) the firefighter spent at least 14 years as an on-call firefighter for the municipality, (iii) the firefighter applies for such creditable service within 30 days after the effective date of this amendatory Act of 1989, (iv) the firefighter

contributes to the Fund an amount representing employee contributions for the number of years of creditable service granted under this subdivision (4), based on the salary and contribution rate in effect for the firefighter at the date of entry into the Fund, to be determined by the board, and (v) not more than 3 years of creditable service may be granted under this subdivision (4).

Except as provided in Section 4-108.5, creditable service shall not include time spent as a volunteer firefighter, whether or not any compensation was received therefor. The change made in this Section by Public Act 83-0463 is intended to be a restatement and clarification of existing law, and does not imply that creditable service was previously allowed under this Article for time spent as a volunteer firefighter.

(5) Time served between July 1, 1976 and July 1, 1988 in the position of protective inspection officer or administrative assistant for fire services, for a municipality with a population under 10,000 that is located in a county with a population over 3,000,000 and that maintains a firefighters' pension fund under this Article, if the position included firefighting duties, notwithstanding that the person may not have held an appointment as a firefighter, provided that application is made to the pension fund within 30 days after the effective date of this amendatory Act of 1991, and the corresponding contributions are paid for the number of years of service granted, based upon the salary and contribution rate in effect for the firefighter at the date of entry into the pension fund, as determined by the Board.

(6) Service before becoming a participant by a firefighter initially excluded from participation by reason of age who becomes a participant under the amendment to Section 4-107 made by this amendatory Act of 1993 and pays the required contributions for such service.

(7) Up to 3 years of time during which the firefighter receives a disability pension under Section 4-110, 4-110.1, or 4-111, provided that (i) the firefighter returns to active service after the disability for a period at least equal to the period for which credit is to be established and (ii) the firefighter makes contributions to the fund based on the rates specified in Section 4-118.1 and the salary upon which the disability pension is based. These contributions may be paid at any time prior to the commencement of a retirement pension. The firefighter may, but need not, elect to have the contributions deducted from the disability pension or to pay them in installments on a schedule approved by the board. If not deducted from the disability pension, the contributions shall include interest at the rate of 6% per year, compounded annually, from the date for which service credit is being established to the date of payment. If contributions are paid under this subdivision (c)(7) in excess of those needed to establish the credit, the excess shall be refunded. This subdivision (c)(7) applies to persons receiving a disability pension under Section 4-110, 4-110.1, or 4-111 on the effective date of this amendatory Act of the 91st General Assembly, as well as persons who begin to receive such a disability pension after that date.

(8) Up to 6 years of service as a police officer and participant in an Article 3 police pension fund administered by the unit of local government that employs the firefighter under this Article, provided that the service has been transferred to, and the required payment received by, the Article 4 fund in accordance with subsection (a) of Section 3-110.12 of this Code.

(9) Up to 8 years of service as a police officer and participant in an Article 3 police pension fund administered by a unit of local government, provided that the service has been transferred to, and the required payment received by, the Article 4 fund in accordance with subsection (a-5) of Section 3-110.12 of this Code.

(10) Up to 8 years of service as a police officer and participant in an Article 3 police pension fund administered by a unit of local government, provided that: (1) the service has been transferred to, and the required payment has been received by, the Article 4 fund in accordance with subsection (a-10) of Section 3-110.12 of this Code; and (2) payment to the fund has been made in an amount, determined by the board, equal to (i) the difference between the amount of employee and employer contributions transferred to the fund under subsection (a-10) of Section 3-110.12 and the amounts that would have been contributed had such contributions been made at the rates applicable to a firefighter under this Article, plus (ii) interest thereon at the actuarially assumed rate, compounded annually, from the date of service to the date of payment.

(Source: P.A. 102-63, eff. 7-9-21; 103-426, eff. 8-4-23.)

Article 27.

Section 27-5. The Illinois Pension Code is amended by changing Section 9-179.1 as follows:

(40 ILCS 5/9-179.1) (from Ch. 108 1/2, par. 9-179.1)

Sec. 9-179.1. Military service. A contributing employee may elect to purchase creditable service for up to 24 months of active-duty military service, whether or not that service followed service as a county employee. The military service need not have been served in wartime, but the employee must not have been dishonorably discharged. To establish this creditable service, the contributing employee must pay to the Fund, while in the service of the county, an amount determined by the Fund to represent (i) the employee contributions for the creditable service based on his or her rate of compensation on his or her last day as a contributor before the military service or on his or her first day as a contributor after the military service, whichever is greater, plus (ii) interest calculated at the effective rate from the date used to determine the rate of compensation for employee contributions under item (i) to the date of payment. ~~A contributing employee may apply for creditable service for up to 2 years of military service whether or not the military service followed service as a county employee. The military service need not have been served in wartime, but the employee must not have been dishonorably discharged. To establish this creditable service the applicant must pay to the Fund, while in the service of the county, an amount determined by the Fund to represent the employee contributions for the creditable service established, based on the employee's rate of compensation on his or her last day as a contributor before the military service, or on his or her first day as a contributor after the military service, whichever is greater, plus interest at the effective rate from the date of discharge to the date of payment. If a person who has established any credit under this Section applies for or receives any early retirement incentive under Section 9-134.2, the credit under this Section shall be forfeited and the amount paid to the Fund under this Section shall be refunded.~~

(Source: P.A. 103-529, eff. 8-11-23.)

Article 30.

Section 30-5. The Illinois Pension Code is amended by adding Sections 3-110.15 and 4-108.9 as follows:

(40 ILCS 5/3-110.15 new)

Sec. 3-110.15. Transfer from Article 4 fund. Until 6 months after the effective date of this amendatory Act of the 104th General Assembly, a person may transfer to a fund established under this Article up to 8 years of creditable service accumulated in a firefighter pension fund under Article 4 that is administered by a unit of local government, if that active member was not subject to disciplinary action when he or she terminated employment with that employer, upon payment to the fund of an amount to be determined by the board, equal to (i) the difference between the amount of employee and employer contributions transferred to the fund under Section 4-108.9 and the amounts that would have been contributed had such contributions been made at the rates applicable to a police officer under this Article, plus (ii) interest thereon at the actuarially assumed rate, compounded annually, from the date of service to the date of payment.

(40 ILCS 5/4-108.9 new)

Sec. 4-108.9. Transfer to Article 3 fund.

(a) At any time during the 6 months following the effective date of this amendatory Act of the 104th General Assembly, an active member of an Article 3 police pension fund may apply for transfer to that fund of up to 8 years of his or her creditable service accumulated in a firefighter pension fund under this Article that is administered by a unit of local government if that active member was not subject to disciplinary action when he or she terminated employment with that employer. The creditable service shall be transferred upon payment by the firefighter pension fund to the Article 3 fund of an amount equal to:

(1) the amounts accumulated to the credit of the applicant on the books of the fund on the date of transfer for the service to be transferred; and

(2) employer contributions in an amount equal to the amount determined under item (1); and

(3) any interest paid by the applicant in order to reinstate service.

Participation in the firefighter pension fund with respect to the transferred creditable service shall terminate on the date of transfer.

(b) At the time of applying for transfer of creditable service under this Section, an active member of an Article 3 police pension fund may, for the purpose of that transfer, reinstate creditable service that was terminated by receipt of a refund, by payment to the police pension fund of the amount of the refund with interest thereon at the rate of 6% per year, compounded annually, from the date of the refund to the date of payment.

Article 33.

Section 33-5. The Illinois Pension Code is amended by adding Section 8-207.1 as follows:

(40 ILCS 5/8-207.1 new)

Sec. 8-207.1. To reproduce records. To have any records kept by the board photographed, microfilmed, or digitally or electronically reproduced in accordance with the Local Records Act. The photographs, microfilm, and digital and electronic reproductions shall be deemed original records and documents for all purposes, including introduction in evidence before all courts and administrative agencies.

Article 34.

Section 34-5. The Illinois Pension Code is amended by changing Sections 14-110 and 14-152.1 as follows:

(40 ILCS 5/14-110) (from Ch. 108 1/2, par. 14-110)

(Text of Section from P.A. 102-813 and 103-34)

Sec. 14-110. Alternative retirement annuity.

(a) Any member who has withdrawn from service with not less than 20 years of eligible creditable service and has attained age 55, and any member who has withdrawn from service with not less than 25 years of eligible creditable service and has attained age 50, regardless of whether the attainment of either of the specified ages occurs while the member is still in service, shall be entitled to receive at the option of the member, in lieu of the regular or minimum retirement annuity, a retirement annuity computed as follows:

(i) for periods of service as a noncovered employee: if retirement occurs on or after January 1, 2001, 3% of final average compensation for each year of creditable service; if retirement occurs before January 1, 2001, 2 1/4% of final average compensation for each of the first 10 years of creditable service, 2 1/2% for each year above 10 years to and including 20 years of creditable service, and 2 3/4% for each year of creditable service above 20 years; and

(ii) for periods of eligible creditable service as a covered employee: if retirement occurs on or after January 1, 2001, 2.5% of final average compensation for each year of creditable service; if retirement occurs before January 1, 2001, 1.67% of final average compensation for each of the first 10 years of such service, 1.90% for each of the next 10 years of such service, 2.10% for each year of such service in excess of 20 but not exceeding 30, and 2.30% for each year in excess of 30.

Such annuity shall be subject to a maximum of 75% of final average compensation if retirement occurs before January 1, 2001 or to a maximum of 80% of final average compensation if retirement occurs on or after January 1, 2001.

These rates shall not be applicable to any service performed by a member as a covered employee which is not eligible creditable service. Service as a covered employee which is not eligible creditable service shall be subject to the rates and provisions of Section 14-108.

(a-5) A member who is eligible to receive an alternative retirement annuity under this Section may elect to receive an estimated payment that shall commence no later than 30 days after the later of either the member's last day of employment or 30 days after the member files for the retirement benefit with the System. The estimated payment shall be the best estimate by the System of the total monthly amount due to the member based on the information that the System possesses at the time of the estimate. If the amount of the estimate is greater or less than the actual amount of the monthly annuity, the System shall pay or recover the difference within 6 months after the start of the monthly annuity.

(b) For the purpose of this Section, "eligible creditable service" means creditable service resulting from service in one or more of the following positions:

(1) State policeman;

(2) fire fighter in the fire protection service of a department;

(3) air pilot;

(4) special agent;

(5) investigator for the Secretary of State;

(6) conservation police officer;

(7) investigator for the Department of Revenue or the Illinois Gaming Board;

(8) security employee of the Department of Human Services;

(9) Central Management Services security police officer;

(10) security employee of the Department of Corrections or the Department of Juvenile Justice;
(11) dangerous drugs investigator;
(12) investigator for the Illinois State Police;
(13) investigator for the Office of the Attorney General;
(14) controlled substance inspector;
(15) investigator for the Office of the State's Attorneys Appellate Prosecutor;
(16) Commerce Commission police officer;
(17) arson investigator;
(18) State highway maintenance worker;
(19) security employee of the Department of Innovation and Technology; or
(20) transferred employee.

A person employed in one of the positions specified in this subsection is entitled to eligible creditable service for service credit earned under this Article while undergoing the basic police training course approved by the Illinois Law Enforcement Training Standards Board, if completion of that training is required of persons serving in that position. For the purposes of this Code, service during the required basic police training course shall be deemed performance of the duties of the specified position, even though the person is not a sworn peace officer at the time of the training.

A person under paragraph (20) is entitled to eligible creditable service for service credit earned under this Article on and after his or her transfer by Executive Order No. 2003-10, Executive Order No. 2004-2, or Executive Order No. 2016-1.

(c) For the purposes of this Section:

(1) The term "State policeman" includes any title or position in the Illinois State Police that is held by an individual employed under the Illinois State Police Act.

(2) The term "fire fighter in the fire protection service of a department" includes all officers in such fire protection service including fire chiefs and assistant fire chiefs.

(3) The term "air pilot" includes any employee whose official job description on file in the Department of Central Management Services, or in the department by which he is employed if that department is not covered by the Personnel Code, states that his principal duty is the operation of aircraft, and who possesses a pilot's license; however, the change in this definition made by Public Act 83-842 shall not operate to exclude any noncovered employee who was an "air pilot" for the purposes of this Section on January 1, 1984.

(4) The term "special agent" means any person who by reason of employment by the Division of Narcotic Control, the Bureau of Investigation or, after July 1, 1977, the Division of Criminal Investigation, the Division of Internal Investigation, the Division of Operations, the Division of Patrol, or any other Division or organizational entity in the Illinois State Police is vested by law with duties to maintain public order, investigate violations of the criminal law of this State, enforce the laws of this State, make arrests and recover property. The term "special agent" includes any title or position in the Illinois State Police that is held by an individual employed under the Illinois State Police Act.

(5) The term "investigator for the Secretary of State" means any person employed by the Office of the Secretary of State and vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

A person who became employed as an investigator for the Secretary of State between January 1, 1967 and December 31, 1975, and who has served as such until attainment of age 60, either continuously or with a single break in service of not more than 3 years duration, which break terminated before January 1, 1976, shall be entitled to have his retirement annuity calculated in accordance with subsection (a), notwithstanding that he has less than 20 years of credit for such service.

(6) The term "Conservation Police Officer" means any person employed by the Division of Law Enforcement of the Department of Natural Resources and vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act. The term "Conservation Police Officer" includes the positions of Chief Conservation Police Administrator and Assistant Conservation Police Administrator.

(7) The term "investigator for the Department of Revenue" means any person employed by the Department of Revenue and vested with such investigative duties as render him ineligible for

coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

The term "investigator for the Illinois Gaming Board" means any person employed as such by the Illinois Gaming Board and vested with such peace officer duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act.

(8) The term "security employee of the Department of Human Services" means any person employed by the Department of Human Services who (i) is employed at the Chester Mental Health Center and has daily contact with the residents thereof, (ii) is employed within a security unit at a facility operated by the Department and has daily contact with the residents of the security unit, (iii) is employed at a facility operated by the Department that includes a security unit and is regularly scheduled to work at least 50% of his or her working hours within that security unit, or (iv) is a mental health police officer. "Mental health police officer" means any person employed by the Department of Human Services in a position pertaining to the Department's mental health and developmental disabilities functions who is vested with such law enforcement duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. "Security unit" means that portion of a facility that is devoted to the care, containment, and treatment of persons committed to the Department of Human Services as sexually violent persons, persons unfit to stand trial, or persons not guilty by reason of insanity. With respect to past employment, references to the Department of Human Services include its predecessor, the Department of Mental Health and Developmental Disabilities.

The changes made to this subdivision (c)(8) by Public Act 92-14 apply to persons who retire on or after January 1, 2001, notwithstanding Section 1-103.1.

(9) "Central Management Services security police officer" means any person employed by the Department of Central Management Services who is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

(10) For a member who first became an employee under this Article before July 1, 2005, the term "security employee of the Department of Corrections or the Department of Juvenile Justice" means any employee of the Department of Corrections or the Department of Juvenile Justice or the former Department of Personnel, and any member or employee of the Prisoner Review Board, who has daily contact with inmates or youth by working within a correctional facility or Juvenile facility operated by the Department of Juvenile Justice or who is a parole officer or an employee who has direct contact with committed persons in the performance of his or her job duties. For a member who first becomes an employee under this Article on or after July 1, 2005, the term means an employee of the Department of Corrections or the Department of Juvenile Justice who is any of the following: (i) officially headquartered at a correctional facility or Juvenile facility operated by the Department of Juvenile Justice, (ii) a parole officer, (iii) a member of the apprehension unit, (iv) a member of the intelligence unit, (v) a member of the sort team, or (vi) an investigator.

(11) The term "dangerous drugs investigator" means any person who is employed as such by the Department of Human Services.

(12) The term "investigator for the Illinois State Police" means a person employed by the Illinois State Police who is vested under Section 4 of the Narcotic Control Division Abolition Act with such law enforcement powers as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

(13) "Investigator for the Office of the Attorney General" means any person who is employed as such by the Office of the Attorney General and is vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. For the period before January 1, 1989, the term includes all persons who were employed as investigators by the Office of the Attorney General, without regard to social security status.

(14) "Controlled substance inspector" means any person who is employed as such by the Department of Professional Regulation and is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. The term "controlled substance inspector" includes the Program Executive of Enforcement and the Assistant Program Executive of Enforcement.

(15) The term "investigator for the Office of the State's Attorneys Appellate Prosecutor" means a person employed in that capacity on a full-time basis under the authority of Section 7.06 of the State's Attorneys Appellate Prosecutor's Act.

(16) "Commerce Commission police officer" means any person employed by the Illinois Commerce Commission who is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act.

(17) "Arson investigator" means any person who is employed as such by the Office of the State Fire Marshal and is vested with such law enforcement duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act. A person who was employed as an arson investigator on January 1, 1995 and is no longer in service but not yet receiving a retirement annuity may convert his or her creditable service for employment as an arson investigator into eligible creditable service by paying to the System the difference between the employee contributions actually paid for that service and the amounts that would have been contributed if the applicant were contributing at the rate applicable to persons with the same social security status earning eligible creditable service on the date of application.

(18) The term "State highway maintenance worker" means a person who is either of the following:

(i) A person employed on a full-time basis by the Illinois Department of Transportation in the position of highway maintainer, highway maintenance lead worker, highway maintenance lead/lead worker, heavy construction equipment operator, power shovel operator, or bridge mechanic; and whose principal responsibility is to perform, on the roadway, the actual maintenance necessary to keep the highways that form a part of the State highway system in serviceable condition for vehicular traffic.

(ii) A person employed on a full-time basis by the Illinois State Toll Highway Authority in the position of equipment operator/laborer H-4, equipment operator/laborer H-6, welder H-4, welder H-6, mechanical/electrical H-4, mechanical/electrical H-6, water/sewer H-4, water/sewer H-6, sign maker/hanger H-4, sign maker/hanger H-6, roadway lighting H-4, roadway lighting H-6, structural H-4, structural H-6, painter H-4, or painter H-6; and whose principal responsibility is to perform, on the roadway, the actual maintenance necessary to keep the Authority's tollways in serviceable condition for vehicular traffic.

(19) The term "security employee of the Department of Innovation and Technology" means a person who was a security employee of the Department of Corrections or the Department of Juvenile Justice, was transferred to the Department of Innovation and Technology pursuant to Executive Order 2016-01, and continues to perform similar job functions under that Department.

(20) "Transferred employee" means an employee who was transferred to the Department of Central Management Services by Executive Order No. 2003-10 or Executive Order No. 2004-2 or transferred to the Department of Innovation and Technology by Executive Order No. 2016-1, or both, and was entitled to eligible creditable service for services immediately preceding the transfer.

(d) A security employee of the Department of Corrections or the Department of Juvenile Justice, a security employee of the Department of Human Services who is not a mental health police officer, and a security employee of the Department of Innovation and Technology shall not be eligible for the alternative retirement annuity provided by this Section unless he or she meets the following minimum age and service requirements at the time of retirement:

(i) 25 years of eligible creditable service and age 55; or

(ii) beginning January 1, 1987, 25 years of eligible creditable service and age 54, or 24 years of eligible creditable service and age 55; or

(iii) beginning January 1, 1988, 25 years of eligible creditable service and age 53, or 23 years of eligible creditable service and age 55; or

(iv) beginning January 1, 1989, 25 years of eligible creditable service and age 52, or 22 years of eligible creditable service and age 55; or

(v) beginning January 1, 1990, 25 years of eligible creditable service and age 51, or 21 years of eligible creditable service and age 55; or

(vi) beginning January 1, 1991, 25 years of eligible creditable service and age 50, or 20 years of eligible creditable service and age 55.

Persons who have service credit under Article 16 of this Code for service as a security employee of the Department of Corrections or the Department of Juvenile Justice, or the Department of Human Services in a position requiring certification as a teacher may count such service toward establishing their eligibility under the service requirements of this Section; but such service may be used only for establishing such eligibility, and not for the purpose of increasing or calculating any benefit.

(e) If a member enters military service while working in a position in which eligible creditable service may be earned, and returns to State service in the same or another such position, and fulfills in all other respects the conditions prescribed in this Article for credit for military service, such military service shall be credited as eligible creditable service for the purposes of the retirement annuity prescribed in this Section.

(f) For purposes of calculating retirement annuities under this Section, periods of service rendered after December 31, 1968 and before October 1, 1975 as a covered employee in the position of special agent, conservation police officer, mental health police officer, or investigator for the Secretary of State, shall be deemed to have been service as a noncovered employee, provided that the employee pays to the System prior to retirement an amount equal to (1) the difference between the employee contributions that would have been required for such service as a noncovered employee, and the amount of employee contributions actually paid, plus (2) if payment is made after July 31, 1987, regular interest on the amount specified in item (1) from the date of service to the date of payment.

For purposes of calculating retirement annuities under this Section, periods of service rendered after December 31, 1968 and before January 1, 1982 as a covered employee in the position of investigator for the Department of Revenue shall be deemed to have been service as a noncovered employee, provided that the employee pays to the System prior to retirement an amount equal to (1) the difference between the employee contributions that would have been required for such service as a noncovered employee, and the amount of employee contributions actually paid, plus (2) if payment is made after January 1, 1990, regular interest on the amount specified in item (1) from the date of service to the date of payment.

(g) A State policeman may elect, not later than January 1, 1990, to establish eligible creditable service for up to 10 years of his service as a policeman under Article 3, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.5, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman may elect, not later than July 1, 1993, to establish eligible creditable service for up to 10 years of his service as a member of the County Police Department under Article 9, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 9-121.10 and the amounts that would have been contributed had those contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(h) Subject to the limitation in subsection (i), a State policeman or investigator for the Secretary of State may elect to establish eligible creditable service for up to 12 years of his service as a policeman under Article 5, by filing a written election with the Board on or before January 31, 1992, and paying to the System by January 31, 1994 an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 5-236, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 10 years of service as a sheriff's law enforcement employee under Article 7, by filing a written election with the Board on or before January 31, 1993, and paying to the System by January 31, 1994 an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 7-139.7, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 5 years of service as a police officer under Article 3, a policeman under Article 5, a sheriff's law enforcement employee under Article 7, a member of the county police department under Article 9, or a police officer under Article 15 by filing a written election with the Board and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6, 5-236, 7-139.8, 9-121.10, or 15-134.4 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), an investigator for the Office of the Attorney General, or an investigator for the Department of Revenue, may elect to establish eligible creditable service for up to 5 years of service as a police officer under Article 3, a policeman under Article 5, a sheriff's law enforcement employee under Article 7, or a member of the county police department under Article 9 by filing a written election with the Board within 6 months after August 25, 2009 (the effective date of Public Act 96-745) and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6, 5-236, 7-139.8, or 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, investigator for the Office of the Attorney General, an investigator for the Department of Revenue, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties, or law enforcement officer employed on a full-time basis by a forest preserve district under Article 7, a county corrections officer, or a court services officer under Article 9, by filing a written election with the Board within 6 months after August 25, 2009 (the effective date of Public Act 96-745) and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 7-139.8 and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, arson investigator, or Commerce Commission police officer may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, a court services officer under Article 9, or a firefighter under Article 4 by filing a written election with the Board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 4-108.8, 7-139.8, and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a conservation police officer may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, or a court services officer under Article 9 by filing a written election with the Board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 7-139.8 and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Notwithstanding the limitation in subsection (i), a State policeman or conservation police officer may elect to convert service credit earned under this Article to eligible creditable service, as defined by this Section, by filing a written election with the board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee contributions originally paid for that service and the amounts

that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) the difference between the employer's normal cost of the credit prior to the conversion authorized by Public Act 102-210 and the employer's normal cost of the credit converted in accordance with Public Act 102-210, plus (iii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

(i) The total amount of eligible creditable service established by any person under subsections (g), (h), (j), (k), (l), (l-5), and (o) of this Section shall not exceed 12 years.

(j) Subject to the limitation in subsection (i), an investigator for the Office of the State's Attorneys Appellate Prosecutor or a controlled substance inspector may elect to establish eligible creditable service for up to 10 years of his service as a policeman under Article 3 or a sheriff's law enforcement employee under Article 7, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (1) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6 or 7-139.8, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (2) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(k) Subject to the limitation in subsection (i) of this Section, an alternative formula employee may elect to establish eligible creditable service for periods spent as a full-time law enforcement officer or full-time corrections officer employed by the federal government or by a state or local government located outside of Illinois, for which credit is not held in any other public employee pension fund or retirement system. To obtain this credit, the applicant must file a written application with the Board by March 31, 1998, accompanied by evidence of eligibility acceptable to the Board and payment of an amount to be determined by the Board, equal to (1) employee contributions for the credit being established, based upon the applicant's salary on the first day as an alternative formula employee after the employment for which credit is being established and the rates then applicable to alternative formula employees, plus (2) an amount determined by the Board to be the employer's normal cost of the benefits accrued for the credit being established, plus (3) regular interest on the amounts in items (1) and (2) from the first day as an alternative formula employee after the employment for which credit is being established to the date of payment.

(l) Subject to the limitation in subsection (i), a security employee of the Department of Corrections may elect, not later than July 1, 1998, to establish eligible creditable service for up to 10 years of his or her service as a policeman under Article 3, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.5, and the amounts that would have been contributed had such contributions been made at the rates applicable to security employees of the Department of Corrections, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(l-5) Subject to the limitation in subsection (i) of this Section, a State policeman may elect to establish eligible creditable service for up to 5 years of service as a full-time law enforcement officer employed by the federal government or by a state or local government located outside of Illinois for which credit is not held in any other public employee pension fund or retirement system. To obtain this credit, the applicant must file a written application with the Board no later than 3 years after January 1, 2020 (the effective date of Public Act 101-610), accompanied by evidence of eligibility acceptable to the Board and payment of an amount to be determined by the Board, equal to (1) employee contributions for the credit being established, based upon the applicant's salary on the first day as an alternative formula employee after the employment for which credit is being established and the rates then applicable to alternative formula employees, plus (2) an amount determined by the Board to be the employer's normal cost of the benefits accrued for the credit being established, plus (3) regular interest on the amounts in items (1) and (2) from the first day as an alternative formula employee after the employment for which credit is being established to the date of payment.

(m) The amendatory changes to this Section made by Public Act 94-696 apply only to: (1) security employees of the Department of Juvenile Justice employed by the Department of Corrections before June 1, 2006 (the effective date of Public Act 94-696) and transferred to the Department of Juvenile Justice by Public Act 94-696; and (2) persons employed by the Department of Juvenile Justice on or after June 1, 2006 (the effective date of Public Act 94-696) who are required by subsection (b) of Section 3-2.5-15 of the Unified Code of Corrections to have any bachelor's or advanced degree from an accredited college or university or, in the case of persons who provide vocational training, who are required to have adequate knowledge in the skill for which they are providing the vocational training.

(n) A person employed in a position under subsection (b) of this Section who has purchased service credit under subsection (j) of Section 14-104 or subsection (b) of Section 14-105 in any other capacity under this Article may convert up to 5 years of that service credit into service credit covered under this Section by paying to the Fund an amount equal to (1) the additional employee contribution required under Section 14-133, plus (2) the additional employer contribution required under Section 14-131, plus (3) interest on items (1) and (2) at the actuarially assumed rate from the date of the service to the date of payment.

(o) Subject to the limitation in subsection (i), a conservation police officer, investigator for the Secretary of State, Commerce Commission police officer, investigator for the Department of Revenue or the Illinois Gaming Board, or arson investigator subject to subsection (g) of Section 1-160 may elect to convert up to 8 years of service credit established before January 1, 2020 (the effective date of Public Act 101-610) as a conservation police officer, investigator for the Secretary of State, Commerce Commission police officer, investigator for the Department of Revenue or the Illinois Gaming Board, or arson investigator under this Article into eligible creditable service by filing a written election with the Board no later than one year after January 1, 2020 (the effective date of Public Act 101-610), accompanied by payment of an amount to be determined by the Board equal to (i) the difference between the amount of the employee contributions actually paid for that service and the amount of the employee contributions that would have been paid had the employee contributions been made as a noncovered employee serving in a position in which eligible creditable service, as defined in this Section, may be earned, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.
(Source: P.A. 102-210, eff. 7-30-21; 102-538, eff. 8-20-21; 102-813, eff. 5-13-22; 103-34, eff. 1-1-24.)

(Text of Section from P.A. 102-856 and 103-34)

Sec. 14-110. Alternative retirement annuity.

(a) Any member who has withdrawn from service with not less than 20 years of eligible creditable service and has attained age 55, and any member who has withdrawn from service with not less than 25 years of eligible creditable service and has attained age 50, regardless of whether the attainment of either of the specified ages occurs while the member is still in service, shall be entitled to receive at the option of the member, in lieu of the regular or minimum retirement annuity, a retirement annuity computed as follows:

(i) for periods of service as a noncovered employee: if retirement occurs on or after January 1, 2001, 3% of final average compensation for each year of creditable service; if retirement occurs before January 1, 2001, 2 1/4% of final average compensation for each of the first 10 years of creditable service, 2 1/2% for each year above 10 years to and including 20 years of creditable service, and 2 3/4% for each year of creditable service above 20 years; and

(ii) for periods of eligible creditable service as a covered employee: if retirement occurs on or after January 1, 2001, 2.5% of final average compensation for each year of creditable service; if retirement occurs before January 1, 2001, 1.67% of final average compensation for each of the first 10 years of such service, 1.90% for each of the next 10 years of such service, 2.10% for each year of such service in excess of 20 but not exceeding 30, and 2.30% for each year in excess of 30.

Such annuity shall be subject to a maximum of 75% of final average compensation if retirement occurs before January 1, 2001 or to a maximum of 80% of final average compensation if retirement occurs on or after January 1, 2001.

These rates shall not be applicable to any service performed by a member as a covered employee which is not eligible creditable service. Service as a covered employee which is not eligible creditable service shall be subject to the rates and provisions of Section 14-108.

(a-5) A member who is eligible to receive an alternative retirement annuity under this Section may elect to receive an estimated payment that shall commence no later than 30 days after the later of either the member's last day of employment or 30 days after the member files for the retirement benefit with the System. The estimated payment shall be the best estimate by the System of the total monthly amount due to the member based on the information that the System possesses at the time of the estimate. If the amount of the estimate is greater or less than the actual amount of the monthly annuity, the System shall pay or recover the difference within 6 months after the start of the monthly annuity.

(b) For the purpose of this Section, "eligible creditable service" means creditable service resulting from service in one or more of the following positions:

(1) State policeman;

(2) fire fighter in the fire protection service of a department;

(3) air pilot;

(4) special agent;
(5) investigator for the Secretary of State;
(6) conservation police officer;
(7) investigator for the Department of Revenue or the Illinois Gaming Board;
(8) security employee of the Department of Human Services;
(9) Central Management Services security police officer;
(10) security employee of the Department of Corrections or the Department of Juvenile Justice;
(11) dangerous drugs investigator;
(12) investigator for the Illinois State Police;
(13) investigator for the Office of the Attorney General;
(14) controlled substance inspector;
(15) investigator for the Office of the State's Attorneys Appellate Prosecutor;
(16) Commerce Commission police officer;
(17) arson investigator;
(18) State highway maintenance worker;
(19) security employee of the Department of Innovation and Technology; or
(20) transferred employee.

A person employed in one of the positions specified in this subsection is entitled to eligible creditable service for service credit earned under this Article while undergoing the basic police training course approved by the Illinois Law Enforcement Training Standards Board, if completion of that training is required of persons serving in that position. For the purposes of this Code, service during the required basic police training course shall be deemed performance of the duties of the specified position, even though the person is not a sworn peace officer at the time of the training.

A person under paragraph (20) is entitled to eligible creditable service for service credit earned under this Article on and after his or her transfer by Executive Order No. 2003-10, Executive Order No. 2004-2, or Executive Order No. 2016-1.

(c) For the purposes of this Section:

(1) The term "State policeman" includes any title or position in the Illinois State Police that is held by an individual employed under the Illinois State Police Act.

(2) The term "fire fighter in the fire protection service of a department" includes all officers in such fire protection service including fire chiefs and assistant fire chiefs.

(3) The term "air pilot" includes any employee whose official job description on file in the Department of Central Management Services, or in the department by which he is employed if that department is not covered by the Personnel Code, states that his principal duty is the operation of aircraft, and who possesses a pilot's license; however, the change in this definition made by Public Act 83-842 shall not operate to exclude any noncovered employee who was an "air pilot" for the purposes of this Section on January 1, 1984.

(4) The term "special agent" means any person who by reason of employment by the Division of Narcotic Control, the Bureau of Investigation or, after July 1, 1977, the Division of Criminal Investigation, the Division of Internal Investigation, the Division of Operations, the Division of Patrol, or any other Division or organizational entity in the Illinois State Police is vested by law with duties to maintain public order, investigate violations of the criminal law of this State, enforce the laws of this State, make arrests and recover property. The term "special agent" includes any title or position in the Illinois State Police that is held by an individual employed under the Illinois State Police Act.

(5) The term "investigator for the Secretary of State" means any person employed by the Office of the Secretary of State and vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

A person who became employed as an investigator for the Secretary of State between January 1, 1967 and December 31, 1975, and who has served as such until attainment of age 60, either continuously or with a single break in service of not more than 3 years duration, which break terminated before January 1, 1976, shall be entitled to have his retirement annuity calculated in accordance with subsection (a), notwithstanding that he has less than 20 years of credit for such service.

(6) The term "Conservation Police Officer" means any person employed by the Division of Law Enforcement of the Department of Natural Resources and vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act. The term "Conservation Police Officer" includes the positions of Chief Conservation Police Administrator and Assistant Conservation Police Administrator.

(7) The term "investigator for the Department of Revenue" means any person employed by the Department of Revenue and vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

The term "investigator for the Illinois Gaming Board" means any person employed as such by the Illinois Gaming Board and vested with such peace officer duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act.

(8) The term "security employee of the Department of Human Services" means any person employed by the Department of Human Services who (i) is employed at the Chester Mental Health Center and has daily contact with the residents thereof, (ii) is employed within a security unit at a facility operated by the Department and has daily contact with the residents of the security unit, (iii) is employed at a facility operated by the Department that includes a security unit and is regularly scheduled to work at least 50% of his or her working hours within that security unit, or (iv) is a mental health police officer. "Mental health police officer" means any person employed by the Department of Human Services in a position pertaining to the Department's mental health and developmental disabilities functions who is vested with such law enforcement duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. "Security unit" means that portion of a facility that is devoted to the care, containment, and treatment of persons committed to the Department of Human Services as sexually violent persons, persons unfit to stand trial, or persons not guilty by reason of insanity. With respect to past employment, references to the Department of Human Services include its predecessor, the Department of Mental Health and Developmental Disabilities.

The changes made to this subdivision (c)(8) by Public Act 92-14 apply to persons who retire on or after January 1, 2001, notwithstanding Section 1-103.1.

(9) "Central Management Services security police officer" means any person employed by the Department of Central Management Services who is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

(10) For a member who first became an employee under this Article before July 1, 2005, the term "security employee of the Department of Corrections or the Department of Juvenile Justice" means any employee of the Department of Corrections or the Department of Juvenile Justice or the former Department of Personnel, and any member or employee of the Prisoner Review Board, who has daily contact with inmates or youth by working within a correctional facility or Juvenile facility operated by the Department of Juvenile Justice or who is a parole officer or an employee who has direct contact with committed persons in the performance of his or her job duties. For a member who first becomes an employee under this Article on or after July 1, 2005, the term means an employee of the Department of Corrections or the Department of Juvenile Justice who is any of the following: (i) officially headquartered at a correctional facility or Juvenile facility operated by the Department of Juvenile Justice, (ii) a parole officer, (iii) a member of the apprehension unit, (iv) a member of the intelligence unit, (v) a member of the sort team, or (vi) an investigator.

(11) The term "dangerous drugs investigator" means any person who is employed as such by the Department of Human Services.

(12) The term "investigator for the Illinois State Police" means a person employed by the Illinois State Police who is vested under Section 4 of the Narcotic Control Division Abolition Act with such law enforcement powers as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

(13) "Investigator for the Office of the Attorney General" means any person who is employed as such by the Office of the Attorney General and is vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. For the period before January 1, 1989, the term includes all

persons who were employed as investigators by the Office of the Attorney General, without regard to social security status.

(14) "Controlled substance inspector" means any person who is employed as such by the Department of Professional Regulation and is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. The term "controlled substance inspector" includes the Program Executive of Enforcement and the Assistant Program Executive of Enforcement.

(15) The term "investigator for the Office of the State's Attorneys Appellate Prosecutor" means a person employed in that capacity on a full-time basis under the authority of Section 7.06 of the State's Attorneys Appellate Prosecutor's Act.

(16) "Commerce Commission police officer" means any person employed by the Illinois Commerce Commission who is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act.

(17) "Arson investigator" means any person who is employed as such by the Office of the State Fire Marshal and is vested with such law enforcement duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act. A person who was employed as an arson investigator on January 1, 1995 and is no longer in service but not yet receiving a retirement annuity may convert his or her creditable service for employment as an arson investigator into eligible creditable service by paying to the System the difference between the employee contributions actually paid for that service and the amounts that would have been contributed if the applicant were contributing at the rate applicable to persons with the same social security status earning eligible creditable service on the date of application.

(18) The term "State highway maintenance worker" means a person who is either of the following:

(i) A person employed on a full-time basis by the Illinois Department of Transportation in the position of highway maintainer, highway maintenance lead worker, highway maintenance lead/lead worker, heavy construction equipment operator, power shovel operator, or bridge mechanic; and whose principal responsibility is to perform, on the roadway, the actual maintenance necessary to keep the highways that form a part of the State highway system in serviceable condition for vehicular traffic.

(ii) A person employed on a full-time basis by the Illinois State Toll Highway Authority in the position of equipment operator/laborer H-4, equipment operator/laborer H-6, welder H-4, welder H-6, mechanical/electrical H-4, mechanical/electrical H-6, water/sewer H-4, water/sewer H-6, sign maker/hanger H-4, sign maker/hanger H-6, roadway lighting H-4, roadway lighting H-6, structural H-4, structural H-6, painter H-4, or painter H-6; and whose principal responsibility is to perform, on the roadway, the actual maintenance necessary to keep the Authority's tollways in serviceable condition for vehicular traffic.

(19) The term "security employee of the Department of Innovation and Technology" means a person who was a security employee of the Department of Corrections or the Department of Juvenile Justice, was transferred to the Department of Innovation and Technology pursuant to Executive Order 2016-01, and continues to perform similar job functions under that Department.

(20) "Transferred employee" means an employee who was transferred to the Department of Central Management Services by Executive Order No. 2003-10 or Executive Order No. 2004-2 or transferred to the Department of Innovation and Technology by Executive Order No. 2016-1, or both, and was entitled to eligible creditable service for services immediately preceding the transfer.

(d) A security employee of the Department of Corrections or the Department of Juvenile Justice, a security employee of the Department of Human Services who is not a mental health police officer, and a security employee of the Department of Innovation and Technology shall not be eligible for the alternative retirement annuity provided by this Section unless he or she meets the following minimum age and service requirements at the time of retirement:

(i) 25 years of eligible creditable service and age 55; or

(ii) beginning January 1, 1987, 25 years of eligible creditable service and age 54, or 24 years of eligible creditable service and age 55; or

(iii) beginning January 1, 1988, 25 years of eligible creditable service and age 53, or 23 years of eligible creditable service and age 55; or

(iv) beginning January 1, 1989, 25 years of eligible creditable service and age 52, or 22 years of eligible creditable service and age 55; or

(v) beginning January 1, 1990, 25 years of eligible creditable service and age 51, or 21 years of eligible creditable service and age 55; or

(vi) beginning January 1, 1991, 25 years of eligible creditable service and age 50, or 20 years of eligible creditable service and age 55.

Persons who have service credit under Article 16 of this Code for service as a security employee of the Department of Corrections or the Department of Juvenile Justice, or the Department of Human Services in a position requiring certification as a teacher may count such service toward establishing their eligibility under the service requirements of this Section; but such service may be used only for establishing such eligibility, and not for the purpose of increasing or calculating any benefit.

(e) If a member enters military service while working in a position in which eligible creditable service may be earned, and returns to State service in the same or another such position, and fulfills in all other respects the conditions prescribed in this Article for credit for military service, such military service shall be credited as eligible creditable service for the purposes of the retirement annuity prescribed in this Section.

(f) For purposes of calculating retirement annuities under this Section, periods of service rendered after December 31, 1968 and before October 1, 1975 as a covered employee in the position of special agent, conservation police officer, mental health police officer, or investigator for the Secretary of State, shall be deemed to have been service as a noncovered employee, provided that the employee pays to the System prior to retirement an amount equal to (1) the difference between the employee contributions that would have been required for such service as a noncovered employee, and the amount of employee contributions actually paid, plus (2) if payment is made after July 31, 1987, regular interest on the amount specified in item (1) from the date of service to the date of payment.

For purposes of calculating retirement annuities under this Section, periods of service rendered after December 31, 1968 and before January 1, 1982 as a covered employee in the position of investigator for the Department of Revenue shall be deemed to have been service as a noncovered employee, provided that the employee pays to the System prior to retirement an amount equal to (1) the difference between the employee contributions that would have been required for such service as a noncovered employee, and the amount of employee contributions actually paid, plus (2) if payment is made after January 1, 1990, regular interest on the amount specified in item (1) from the date of service to the date of payment.

(g) A State policeman may elect, not later than January 1, 1990, to establish eligible creditable service for up to 10 years of his service as a policeman under Article 3, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.5, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman may elect, not later than July 1, 1993, to establish eligible creditable service for up to 10 years of his service as a member of the County Police Department under Article 9, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 9-121.10 and the amounts that would have been contributed had those contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(h) Subject to the limitation in subsection (i), a State policeman or investigator for the Secretary of State may elect to establish eligible creditable service for up to 12 years of his service as a policeman under Article 5, by filing a written election with the Board on or before January 31, 1992, and paying to the System by January 31, 1994 an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 5-236, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 10 years of service as a sheriff's law enforcement employee under Article 7, by filing a written election with the Board on or before January 31, 1993, and paying to the System by January 31, 1994 an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 7-139.7, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 5 years of service as a police officer under Article 3, a policeman under Article 5, a sheriff's law enforcement employee under Article 7, a member of the county police department under Article 9, or a police officer under Article 15 by filing a written election with the Board and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6, 5-236, 7-139.8, 9-121.10, or 15-134.4 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), an investigator for the Office of the Attorney General, or an investigator for the Department of Revenue, may elect to establish eligible creditable service for up to 5 years of service as a police officer under Article 3, a policeman under Article 5, a sheriff's law enforcement employee under Article 7, or a member of the county police department under Article 9 by filing a written election with the Board within 6 months after August 25, 2009 (the effective date of Public Act 96-745) and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6, 5-236, 7-139.8, or 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, investigator for the Office of the Attorney General, an investigator for the Department of Revenue, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties, or law enforcement officer employed on a full-time basis by a forest preserve district under Article 7, a county corrections officer, or a court services officer under Article 9, by filing a written election with the Board within 6 months after August 25, 2009 (the effective date of Public Act 96-745) and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 7-139.8 and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, arson investigator, or Commerce Commission police officer may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, a court services officer under Article 9, or a firefighter under Article 4 by filing a written election with the Board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 4-108.8, 7-139.8, and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a conservation police officer may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, or a court services officer under Article 9 by filing a written election with the Board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections

7-139.8 and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), an investigator for the Department of Revenue, investigator for the Illinois Gaming Board, investigator for the Secretary of State, or arson investigator may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, a court services officer under Article 9, or a firefighter under Article 4 by filing a written election with the Board within 6 months after the effective date of this amendatory Act of the 102nd General Assembly and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 4-108.8, 7-139.8, and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Notwithstanding the limitation in subsection (i), a State policeman or conservation police officer may elect to convert service credit earned under this Article to eligible creditable service, as defined by this Section, by filing a written election with the board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee contributions originally paid for that service and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) the difference between the employer's normal cost of the credit prior to the conversion authorized by Public Act 102-210 and the employer's normal cost of the credit converted in accordance with Public Act 102-210, plus (iii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Notwithstanding the limitation in subsection (i), an investigator for the Department of Revenue, investigator for the Illinois Gaming Board, investigator for the Secretary of State, or arson investigator may elect to convert service credit earned under this Article to eligible creditable service, as defined by this Section, by filing a written election with the Board within 6 months after the effective date of this amendatory Act of the 102nd General Assembly and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee contributions originally paid for that service and the amounts that would have been contributed had such contributions been made at the rates applicable to investigators for the Department of Revenue, investigators for the Illinois Gaming Board, investigators for the Secretary of State, or arson investigators, plus (ii) the difference between the employer's normal cost of the credit prior to the conversion authorized by this amendatory Act of the 102nd General Assembly and the employer's normal cost of the credit converted in accordance with this amendatory Act of the 102nd General Assembly, plus (iii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

(i) The total amount of eligible creditable service established by any person under subsections (g), (h), (j), (k), (l), (l-5), and (o) of this Section shall not exceed 12 years.

(j) Subject to the limitation in subsection (i), an investigator for the Office of the State's Attorneys Appellate Prosecutor or a controlled substance inspector may elect to establish eligible creditable service for up to 10 years of his service as a policeman under Article 3 or a sheriff's law enforcement employee under Article 7, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (1) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6 or 7-139.8, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (2) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(k) Subject to the limitation in subsection (i) of this Section, an alternative formula employee may elect to establish eligible creditable service for periods spent as a full-time law enforcement officer or full-time corrections officer employed by the federal government or by a state or local government located outside of Illinois, for which credit is not held in any other public employee pension fund or retirement system. To obtain this credit, the applicant must file a written application with the Board by March 31, 1998, accompanied by evidence of eligibility acceptable to the Board and payment of an amount to be determined by the Board, equal to (1) employee contributions for the credit being established, based upon the applicant's salary on the first day as an alternative formula employee after the employment for which credit is being

established and the rates then applicable to alternative formula employees, plus (2) an amount determined by the Board to be the employer's normal cost of the benefits accrued for the credit being established, plus (3) regular interest on the amounts in items (1) and (2) from the first day as an alternative formula employee after the employment for which credit is being established to the date of payment.

(l) Subject to the limitation in subsection (i), a security employee of the Department of Corrections may elect, not later than July 1, 1998, to establish eligible creditable service for up to 10 years of his or her service as a policeman under Article 3, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.5, and the amounts that would have been contributed had such contributions been made at the rates applicable to security employees of the Department of Corrections, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(l-5) Subject to the limitation in subsection (i) of this Section, a State policeman may elect to establish eligible creditable service for up to 5 years of service as a full-time law enforcement officer employed by the federal government or by a state or local government located outside of Illinois for which credit is not held in any other public employee pension fund or retirement system. To obtain this credit, the applicant must file a written application with the Board no later than 3 years after January 1, 2020 (the effective date of Public Act 101-610), accompanied by evidence of eligibility acceptable to the Board and payment of an amount to be determined by the Board, equal to (1) employee contributions for the credit being established, based upon the applicant's salary on the first day as an alternative formula employee after the employment for which credit is being established and the rates then applicable to alternative formula employees, plus (2) an amount determined by the Board to be the employer's normal cost of the benefits accrued for the credit being established, plus (3) regular interest on the amounts in items (1) and (2) from the first day as an alternative formula employee after the employment for which credit is being established to the date of payment.

(m) The amendatory changes to this Section made by Public Act 94-696 apply only to: (1) security employees of the Department of Juvenile Justice employed by the Department of Corrections before June 1, 2006 (the effective date of Public Act 94-696) and transferred to the Department of Juvenile Justice by Public Act 94-696; and (2) persons employed by the Department of Juvenile Justice on or after June 1, 2006 (the effective date of Public Act 94-696) who are required by subsection (b) of Section 3-2.5-15 of the Unified Code of Corrections to have any bachelor's or advanced degree from an accredited college or university or, in the case of persons who provide vocational training, who are required to have adequate knowledge in the skill for which they are providing the vocational training.

(n) A person employed in a position under subsection (b) of this Section who has purchased service credit under subsection (j) of Section 14-104 or subsection (b) of Section 14-105 in any other capacity under this Article may convert up to 5 years of that service credit into service credit covered under this Section by paying to the Fund an amount equal to (1) the additional employee contribution required under Section 14-133, plus (2) the additional employer contribution required under Section 14-131, plus (3) interest on items (1) and (2) at the actuarially assumed rate from the date of the service to the date of payment.

(o) Subject to the limitation in subsection (i), a conservation police officer, investigator for the Secretary of State, Commerce Commission police officer, investigator for the Department of Revenue or the Illinois Gaming Board, or arson investigator subject to subsection (g) of Section 1-160 may elect to convert up to 8 years of service credit established before January 1, 2020 (the effective date of Public Act 101-610) as a conservation police officer, investigator for the Secretary of State, Commerce Commission police officer, investigator for the Department of Revenue or the Illinois Gaming Board, or arson investigator under this Article into eligible creditable service by filing a written election with the Board no later than one year after January 1, 2020 (the effective date of Public Act 101-610), accompanied by payment of an amount to be determined by the Board equal to (i) the difference between the amount of the employee contributions actually paid for that service and the amount of the employee contributions that would have been paid had the employee contributions been made as a noncovered employee serving in a position in which eligible creditable service, as defined in this Section, may be earned, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(Source: P.A. 102-210, eff. 7-30-21; 102-538, eff. 8-20-21; 102-856, eff. 1-1-23; 103-34, eff. 1-1-24.)

(Text of Section from P.A. 102-956 and 103-34)

Sec. 14-110. Alternative retirement annuity.

(a) Any member who has withdrawn from service with not less than 20 years of eligible creditable service and has attained age 55, and any member who has withdrawn from service with not less than 25 years of eligible creditable service and has attained age 50, regardless of whether the attainment of either of the specified ages occurs while the member is still in service, shall be entitled to receive at the option of the member, in lieu of the regular or minimum retirement annuity, a retirement annuity computed as follows:

(i) for periods of service as a noncovered employee: if retirement occurs on or after January 1, 2001, 3% of final average compensation for each year of creditable service; if retirement occurs before January 1, 2001, 2 1/4% of final average compensation for each of the first 10 years of creditable service, 2 1/2% for each year above 10 years to and including 20 years of creditable service, and 2 3/4% for each year of creditable service above 20 years; and

(ii) for periods of eligible creditable service as a covered employee: if retirement occurs on or after January 1, 2001, 2.5% of final average compensation for each year of creditable service; if retirement occurs before January 1, 2001, 1.67% of final average compensation for each of the first 10 years of such service, 1.90% for each of the next 10 years of such service, 2.10% for each year of such service in excess of 20 but not exceeding 30, and 2.30% for each year in excess of 30.

Such annuity shall be subject to a maximum of 75% of final average compensation if retirement occurs before January 1, 2001 or to a maximum of 80% of final average compensation if retirement occurs on or after January 1, 2001.

These rates shall not be applicable to any service performed by a member as a covered employee which is not eligible creditable service. Service as a covered employee which is not eligible creditable service shall be subject to the rates and provisions of Section 14-108.

(a-5) A member who is eligible to receive an alternative retirement annuity under this Section may elect to receive an estimated payment that shall commence no later than 30 days after the later of either the member's last day of employment or 30 days after the member files for the retirement benefit with the System. The estimated payment shall be the best estimate by the System of the total monthly amount due to the member based on the information that the System possesses at the time of the estimate. If the amount of the estimate is greater or less than the actual amount of the monthly annuity, the System shall pay or recover the difference within 6 months after the start of the monthly annuity.

(b) For the purpose of this Section, "eligible creditable service" means creditable service resulting from service in one or more of the following positions:

(1) State policeman;
(2) fire fighter in the fire protection service of a department;
(3) air pilot;
(4) special agent;
(5) investigator for the Secretary of State;
(6) conservation police officer;
(7) investigator for the Department of Revenue or the Illinois Gaming Board;
(8) security employee of the Department of Human Services;
(9) Central Management Services security police officer;
(10) security employee of the Department of Corrections or the Department of Juvenile Justice;
(11) dangerous drugs investigator;
(12) investigator for the Illinois State Police;
(13) investigator for the Office of the Attorney General;
(14) controlled substance inspector;
(15) investigator for the Office of the State's Attorneys Appellate Prosecutor;
(16) Commerce Commission police officer;
(17) arson investigator;
(18) State highway maintenance worker;
(19) security employee of the Department of Innovation and Technology; or
(20) transferred employee.

A person employed in one of the positions specified in this subsection is entitled to eligible creditable service for service credit earned under this Article while undergoing the basic police training course approved by the Illinois Law Enforcement Training Standards Board, if completion of that training is required of persons serving in that position. For the purposes of this Code, service during the required basic police training course shall be deemed performance of the duties of the specified position, even though the person is not a sworn peace officer at the time of the training.

A person under paragraph (20) is entitled to eligible creditable service for service credit earned under this Article on and after his or her transfer by Executive Order No. 2003-10, Executive Order No. 2004-2, or Executive Order No. 2016-1.

(c) For the purposes of this Section:

(1) The term "State policeman" includes any title or position in the Illinois State Police that is held by an individual employed under the Illinois State Police Act.

(2) The term "fire fighter in the fire protection service of a department" includes all officers in such fire protection service including fire chiefs and assistant fire chiefs.

(3) The term "air pilot" includes any employee whose official job description on file in the Department of Central Management Services, or in the department by which he is employed if that department is not covered by the Personnel Code, states that his principal duty is the operation of aircraft, and who possesses a pilot's license; however, the change in this definition made by Public Act 83-842 shall not operate to exclude any noncovered employee who was an "air pilot" for the purposes of this Section on January 1, 1984.

(4) The term "special agent" means any person who by reason of employment by the Division of Narcotic Control, the Bureau of Investigation or, after July 1, 1977, the Division of Criminal Investigation, the Division of Internal Investigation, the Division of Operations, the Division of Patrol, or any other Division or organizational entity in the Illinois State Police is vested by law with duties to maintain public order, investigate violations of the criminal law of this State, enforce the laws of this State, make arrests and recover property. The term "special agent" includes any title or position in the Illinois State Police that is held by an individual employed under the Illinois State Police Act.

(5) The term "investigator for the Secretary of State" means any person employed by the Office of the Secretary of State and vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

A person who became employed as an investigator for the Secretary of State between January 1, 1967 and December 31, 1975, and who has served as such until attainment of age 60, either continuously or with a single break in service of not more than 3 years duration, which break terminated before January 1, 1976, shall be entitled to have his retirement annuity calculated in accordance with subsection (a), notwithstanding that he has less than 20 years of credit for such service.

(6) The term "Conservation Police Officer" means any person employed by the Division of Law Enforcement of the Department of Natural Resources and vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act. The term "Conservation Police Officer" includes the positions of Chief Conservation Police Administrator and Assistant Conservation Police Administrator.

(7) The term "investigator for the Department of Revenue" means any person employed by the Department of Revenue and vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

The term "investigator for the Illinois Gaming Board" means any person employed as such by the Illinois Gaming Board and vested with such peace officer duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act.

(8) The term "security employee of the Department of Human Services" means any person employed by the Department of Human Services who (i) is employed at the Chester Mental Health Center and has daily contact with the residents thereof, (ii) is employed within a security unit at a facility operated by the Department and has daily contact with the residents of the security unit, (iii) is employed at a facility operated by the Department that includes a security unit and is regularly scheduled to work at least 50% of his or her working hours within that security unit, or (iv) is a mental health police officer. "Mental health police officer" means any person employed by the Department of Human Services in a position pertaining to the Department's mental health and developmental disabilities functions who is vested with such law enforcement duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. "Security unit" means that portion of a facility that is devoted to the care,

containment, and treatment of persons committed to the Department of Human Services as sexually violent persons, persons unfit to stand trial, or persons not guilty by reason of insanity. With respect to past employment, references to the Department of Human Services include its predecessor, the Department of Mental Health and Developmental Disabilities.

The changes made to this subdivision (c)(8) by Public Act 92-14 apply to persons who retire on or after January 1, 2001, notwithstanding Section 1-103.1.

(9) "Central Management Services security police officer" means any person employed by the Department of Central Management Services who is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

(10) For a member who first became an employee under this Article before July 1, 2005, the term "security employee of the Department of Corrections or the Department of Juvenile Justice" means any employee of the Department of Corrections or the Department of Juvenile Justice or the former Department of Personnel, and any member or employee of the Prisoner Review Board, who has daily contact with inmates or youth by working within a correctional facility or Juvenile facility operated by the Department of Juvenile Justice or who is a parole officer or an employee who has direct contact with committed persons in the performance of his or her job duties. For a member who first becomes an employee under this Article on or after July 1, 2005, the term means an employee of the Department of Corrections or the Department of Juvenile Justice who is any of the following: (i) officially headquartered at a correctional facility or Juvenile facility operated by the Department of Juvenile Justice, (ii) a parole officer, (iii) a member of the apprehension unit, (iv) a member of the intelligence unit, (v) a member of the sort team, or (vi) an investigator.

(11) The term "dangerous drugs investigator" means any person who is employed as such by the Department of Human Services.

(12) The term "investigator for the Illinois State Police" means a person employed by the Illinois State Police who is vested under Section 4 of the Narcotic Control Division Abolition Act with such law enforcement powers as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act.

(13) "Investigator for the Office of the Attorney General" means any person who is employed as such by the Office of the Attorney General and is vested with such investigative duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. For the period before January 1, 1989, the term includes all persons who were employed as investigators by the Office of the Attorney General, without regard to social security status.

(14) "Controlled substance inspector" means any person who is employed as such by the Department of Professional Regulation and is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D) and 218(l)(1) of that Act. The term "controlled substance inspector" includes the Program Executive of Enforcement and the Assistant Program Executive of Enforcement.

(15) The term "investigator for the Office of the State's Attorneys Appellate Prosecutor" means a person employed in that capacity on a full-time basis under the authority of Section 7.06 of the State's Attorneys Appellate Prosecutor's Act.

(16) "Commerce Commission police officer" means any person employed by the Illinois Commerce Commission who is vested with such law enforcement duties as render him ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act.

(17) "Arson investigator" means any person who is employed as such by the Office of the State Fire Marshal and is vested with such law enforcement duties as render the person ineligible for coverage under the Social Security Act by reason of Sections 218(d)(5)(A), 218(d)(8)(D), and 218(l)(1) of that Act. A person who was employed as an arson investigator on January 1, 1995 and is no longer in service but not yet receiving a retirement annuity may convert his or her creditable service for employment as an arson investigator into eligible creditable service by paying to the System the difference between the employee contributions actually paid for that service and the amounts that would have been contributed if the applicant were contributing at the rate applicable to persons with the same social security status earning eligible creditable service on the date of application.

(18) The term "State highway maintenance worker" means a person who is either of the following:

(i) A person employed on a full-time basis by the Illinois Department of Transportation in the position of highway maintainer, highway maintenance lead worker, highway maintenance lead/lead worker, heavy construction equipment operator, power shovel operator, or bridge mechanic; and whose principal responsibility is to perform, on the roadway, the actual maintenance necessary to keep the highways that form a part of the State highway system in serviceable condition for vehicular traffic.

(ii) A person employed on a full-time basis by the Illinois State Toll Highway Authority in the position of equipment operator/laborer H-4, equipment operator/laborer H-6, welder H-4, welder H-6, mechanical/electrical H-4, mechanical/electrical H-6, water/sewer H-4, water/sewer H-6, sign maker/hanger H-4, sign maker/hanger H-6, roadway lighting H-4, roadway lighting H-6, structural H-4, structural H-6, painter H-4, or painter H-6; and whose principal responsibility is to perform, on the roadway, the actual maintenance necessary to keep the Authority's tollways in serviceable condition for vehicular traffic.

(19) The term "security employee of the Department of Innovation and Technology" means a person who was a security employee of the Department of Corrections or the Department of Juvenile Justice, was transferred to the Department of Innovation and Technology pursuant to Executive Order 2016-01, and continues to perform similar job functions under that Department.

(20) "Transferred employee" means an employee who was transferred to the Department of Central Management Services by Executive Order No. 2003-10 or Executive Order No. 2004-2 or transferred to the Department of Innovation and Technology by Executive Order No. 2016-1, or both, and was entitled to eligible creditable service for services immediately preceding the transfer.

(d) A security employee of the Department of Corrections or the Department of Juvenile Justice, a security employee of the Department of Human Services who is not a mental health police officer, and a security employee of the Department of Innovation and Technology shall not be eligible for the alternative retirement annuity provided by this Section unless he or she meets the following minimum age and service requirements at the time of retirement:

(i) 25 years of eligible creditable service and age 55; or

(ii) beginning January 1, 1987, 25 years of eligible creditable service and age 54, or 24 years of eligible creditable service and age 55; or

(iii) beginning January 1, 1988, 25 years of eligible creditable service and age 53, or 23 years of eligible creditable service and age 55; or

(iv) beginning January 1, 1989, 25 years of eligible creditable service and age 52, or 22 years of eligible creditable service and age 55; or

(v) beginning January 1, 1990, 25 years of eligible creditable service and age 51, or 21 years of eligible creditable service and age 55; or

(vi) beginning January 1, 1991, 25 years of eligible creditable service and age 50, or 20 years of eligible creditable service and age 55.

Persons who have service credit under Article 16 of this Code for service as a security employee of the Department of Corrections or the Department of Juvenile Justice, or the Department of Human Services in a position requiring certification as a teacher may count such service toward establishing their eligibility under the service requirements of this Section; but such service may be used only for establishing such eligibility, and not for the purpose of increasing or calculating any benefit.

(e) If a member enters military service while working in a position in which eligible creditable service may be earned, and returns to State service in the same or another such position, and fulfills in all other respects the conditions prescribed in this Article for credit for military service, such military service shall be credited as eligible creditable service for the purposes of the retirement annuity prescribed in this Section.

(f) For purposes of calculating retirement annuities under this Section, periods of service rendered after December 31, 1968 and before October 1, 1975 as a covered employee in the position of special agent, conservation police officer, mental health police officer, or investigator for the Secretary of State, shall be deemed to have been service as a noncovered employee, provided that the employee pays to the System prior to retirement an amount equal to (1) the difference between the employee contributions that would have been required for such service as a noncovered employee, and the amount of employee contributions actually paid, plus (2) if payment is made after July 31, 1987, regular interest on the amount specified in item (1) from the date of service to the date of payment.

For purposes of calculating retirement annuities under this Section, periods of service rendered after December 31, 1968 and before January 1, 1982 as a covered employee in the position of investigator for the Department of Revenue shall be deemed to have been service as a noncovered employee, provided that the employee pays to the System prior to retirement an amount equal to (1) the difference between the employee contributions that would have been required for such service as a noncovered employee, and the amount of employee contributions actually paid, plus (2) if payment is made after January 1, 1990, regular interest on the amount specified in item (1) from the date of service to the date of payment.

(g) A State policeman may elect, not later than January 1, 1990, to establish eligible creditable service for up to 10 years of his service as a policeman under Article 3, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.5, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman may elect, not later than July 1, 1993, to establish eligible creditable service for up to 10 years of his service as a member of the County Police Department under Article 9, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 9-121.10 and the amounts that would have been contributed had those contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(h) Subject to the limitation in subsection (i), a State policeman or investigator for the Secretary of State may elect to establish eligible creditable service for up to 12 years of his service as a policeman under Article 5, by filing a written election with the Board on or before January 31, 1992, and paying to the System by January 31, 1994 an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 5-236, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 10 years of service as a sheriff's law enforcement employee under Article 7, by filing a written election with the Board on or before January 31, 1993, and paying to the System by January 31, 1994 an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 7-139.7, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 5 years of service as a police officer under Article 3, a policeman under Article 5, a sheriff's law enforcement employee under Article 7, a member of the county police department under Article 9, or a police officer under Article 15 by filing a written election with the Board and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6, 5-236, 7-139.8, 9-121.10, or 15-134.4 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), an investigator for the Office of the Attorney General, or an investigator for the Department of Revenue, may elect to establish eligible creditable service for up to 5 years of service as a police officer under Article 3, a policeman under Article 5, a sheriff's law enforcement employee under Article 7, or a member of the county police department under Article 9 by filing a written election with the Board within 6 months after August 25, 2009 (the effective date of Public Act 96-745) and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6, 5-236, 7-139.8, or 9-121.10 and the amounts that would have been contributed had such contributions been made at

the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, conservation police officer, investigator for the Office of the Attorney General, an investigator for the Department of Revenue, or investigator for the Secretary of State may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties, or law enforcement officer employed on a full-time basis by a forest preserve district under Article 7, a county corrections officer, or a court services officer under Article 9, by filing a written election with the Board within 6 months after August 25, 2009 (the effective date of Public Act 96-745) and paying to the System an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 7-139.8 and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a State policeman, arson investigator, or Commerce Commission police officer may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, a court services officer under Article 9, or a firefighter under Article 4 by filing a written election with the Board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 4-108.8, 7-139.8, and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Subject to the limitation in subsection (i), a conservation police officer may elect to establish eligible creditable service for up to 5 years of service as a person employed by a participating municipality to perform police duties under Article 7, a county corrections officer, or a court services officer under Article 9 by filing a written election with the Board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Sections 7-139.8 and 9-121.10 and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

Notwithstanding the limitation in subsection (i), a State policeman or conservation police officer may elect to convert service credit earned under this Article to eligible creditable service, as defined by this Section, by filing a written election with the board within 6 months after July 30, 2021 (the effective date of Public Act 102-210) and paying to the System an amount to be determined by the Board equal to (i) the difference between the amount of employee contributions originally paid for that service and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (ii) the difference between the employer's normal cost of the credit prior to the conversion authorized by Public Act 102-210 and the employer's normal cost of the credit converted in accordance with Public Act 102-210, plus (iii) interest thereon at the actuarially assumed rate for each year, compounded annually, from the date of service to the date of payment.

(i) The total amount of eligible creditable service established by any person under subsections (g), (h), (j), (k), (l), (l-5), (o), and (p) of this Section shall not exceed 12 years.

(j) Subject to the limitation in subsection (i), an investigator for the Office of the State's Attorneys Appellate Prosecutor or a controlled substance inspector may elect to establish eligible creditable service for up to 10 years of his service as a policeman under Article 3 or a sheriff's law enforcement employee under Article 7, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (1) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.6 or 7-139.8, and the amounts that would have been contributed had such contributions been made at the rates applicable to State policemen, plus (2) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(k) Subject to the limitation in subsection (i) of this Section, an alternative formula employee may elect to establish eligible creditable service for periods spent as a full-time law enforcement officer or

full-time corrections officer employed by the federal government or by a state or local government located outside of Illinois, for which credit is not held in any other public employee pension fund or retirement system. To obtain this credit, the applicant must file a written application with the Board by March 31, 1998, accompanied by evidence of eligibility acceptable to the Board and payment of an amount to be determined by the Board, equal to (1) employee contributions for the credit being established, based upon the applicant's salary on the first day as an alternative formula employee after the employment for which credit is being established and the rates then applicable to alternative formula employees, plus (2) an amount determined by the Board to be the employer's normal cost of the benefits accrued for the credit being established, plus (3) regular interest on the amounts in items (1) and (2) from the first day as an alternative formula employee after the employment for which credit is being established to the date of payment.

(l) Subject to the limitation in subsection (i), a security employee of the Department of Corrections may elect, not later than July 1, 1998, to establish eligible creditable service for up to 10 years of his or her service as a policeman under Article 3, by filing a written election with the Board, accompanied by payment of an amount to be determined by the Board, equal to (i) the difference between the amount of employee and employer contributions transferred to the System under Section 3-110.5, and the amounts that would have been contributed had such contributions been made at the rates applicable to security employees of the Department of Corrections, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(l-5) Subject to the limitation in subsection (i) of this Section, a State policeman may elect to establish eligible creditable service for up to 5 years of service as a full-time law enforcement officer employed by the federal government or by a state or local government located outside of Illinois for which credit is not held in any other public employee pension fund or retirement system. To obtain this credit, the applicant must file a written application with the Board no later than 3 years after January 1, 2020 (the effective date of Public Act 101-610), accompanied by evidence of eligibility acceptable to the Board and payment of an amount to be determined by the Board, equal to (1) employee contributions for the credit being established, based upon the applicant's salary on the first day as an alternative formula employee after the employment for which credit is being established and the rates then applicable to alternative formula employees, plus (2) an amount determined by the Board to be the employer's normal cost of the benefits accrued for the credit being established, plus (3) regular interest on the amounts in items (1) and (2) from the first day as an alternative formula employee after the employment for which credit is being established to the date of payment.

(m) The amendatory changes to this Section made by Public Act 94-696 apply only to: (1) security employees of the Department of Juvenile Justice employed by the Department of Corrections before June 1, 2006 (the effective date of Public Act 94-696) and transferred to the Department of Juvenile Justice by Public Act 94-696; and (2) persons employed by the Department of Juvenile Justice on or after June 1, 2006 (the effective date of Public Act 94-696) who are required by subsection (b) of Section 3-2.5-15 of the Unified Code of Corrections to have any bachelor's or advanced degree from an accredited college or university or, in the case of persons who provide vocational training, who are required to have adequate knowledge in the skill for which they are providing the vocational training.

(n) A person employed in a position under subsection (b) of this Section who has purchased service credit under subsection (j) of Section 14-104 or subsection (b) of Section 14-105 in any other capacity under this Article may convert up to 5 years of that service credit into service credit covered under this Section by paying to the Fund an amount equal to (1) the additional employee contribution required under Section 14-133, plus (2) the additional employer contribution required under Section 14-131, plus (3) interest on items (1) and (2) at the actuarially assumed rate from the date of the service to the date of payment.

(o) Subject to the limitation in subsection (i), a conservation police officer, investigator for the Secretary of State, Commerce Commission police officer, investigator for the Department of Revenue or the Illinois Gaming Board, or arson investigator subject to subsection (g) of Section 1-160 may elect to convert up to 8 years of service credit established before January 1, 2020 (the effective date of Public Act 101-610) as a conservation police officer, investigator for the Secretary of State, Commerce Commission police officer, investigator for the Department of Revenue or the Illinois Gaming Board, or arson investigator under this Article into eligible creditable service by filing a written election with the Board no later than one year after January 1, 2020 (the effective date of Public Act 101-610), accompanied by payment of an amount to be determined by the Board equal to (i) the difference between the amount of the employee contributions actually paid for that service and the amount of the employee contributions that would have been paid had the employee contributions been made as a noncovered employee serving in a position in

which eligible creditable service, as defined in this Section, may be earned, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(p) Subject to the limitation in subsection (i), an investigator for the Office of the Attorney General subject to subsection (g) of Section 1-160 may elect to convert up to 8 years of service credit established before the effective date of this amendatory Act of the 102nd General Assembly as an investigator for the Office of the Attorney General under this Article into eligible creditable service by filing a written election with the Board no later than one year after the effective date of this amendatory Act of the 102nd General Assembly, accompanied by payment of an amount to be determined by the Board equal to (i) the difference between the amount of the employee contributions actually paid for that service and the amount of the employee contributions that would have been paid had the employee contributions been made as a noncovered employee serving in a position in which eligible creditable service, as defined in this Section, may be earned, plus (ii) interest thereon at the effective rate for each year, compounded annually, from the date of service to the date of payment.

(Source: P.A. 102-210, eff. 7-30-21; 102-538, eff. 8-20-21; 102-956, eff. 5-27-22; 103-34, eff. 1-1-24.)

(40 ILCS 5/14-152.1)

Sec. 14-152.1. Application and expiration of new benefit increases.

(a) As used in this Section, "new benefit increase" means an increase in the amount of any benefit provided under this Article, or an expansion of the conditions of eligibility for any benefit under this Article, that results from an amendment to this Code that takes effect after June 1, 2005 (the effective date of Public Act 94-4). "New benefit increase", however, does not include any benefit increase resulting from the changes made to Article 1 or this Article by Public Act 96-37, Public Act 100-23, Public Act 100-587, Public Act 100-611, Public Act 101-10, Public Act 101-610, Public Act 102-210, Public Act 102-856, Public Act 102-956, or this amendatory Act of the 104th General Assembly ~~this amendatory Act of the 102nd General Assembly~~.

(b) Notwithstanding any other provision of this Code or any subsequent amendment to this Code, every new benefit increase is subject to this Section and shall be deemed to be granted only in conformance with and contingent upon compliance with the provisions of this Section.

(c) The Public Act enacting a new benefit increase must identify and provide for payment to the System of additional funding at least sufficient to fund the resulting annual increase in cost to the System as it accrues.

Every new benefit increase is contingent upon the General Assembly providing the additional funding required under this subsection. The Commission on Government Forecasting and Accountability shall analyze whether adequate additional funding has been provided for the new benefit increase and shall report its analysis to the Public Pension Division of the Department of Insurance. A new benefit increase created by a Public Act that does not include the additional funding required under this subsection is null and void. If the Public Pension Division determines that the additional funding provided for a new benefit increase under this subsection is or has become inadequate, it may so certify to the Governor and the State Comptroller and, in the absence of corrective action by the General Assembly, the new benefit increase shall expire at the end of the fiscal year in which the certification is made.

(d) Every new benefit increase shall expire 5 years after its effective date or on such earlier date as may be specified in the language enacting the new benefit increase or provided under subsection (c). This does not prevent the General Assembly from extending or re-creating a new benefit increase by law.

(e) Except as otherwise provided in the language creating the new benefit increase, a new benefit increase that expires under this Section continues to apply to persons who applied and qualified for the affected benefit while the new benefit increase was in effect and to the affected beneficiaries and alternate payees of such persons, but does not apply to any other person, including, without limitation, a person who continues in service after the expiration date and did not apply and qualify for the affected benefit while the new benefit increase was in effect.

(Source: P.A. 101-10, eff. 6-5-19; 101-81, eff. 7-12-19; 101-610, eff. 1-1-20; 102-210, eff. 7-30-21; 102-856, eff. 1-1-23; 102-956, eff. 5-27-22.)

Article 35.

Section 35-5. The Illinois Pension Code is amended by changing Section 15-139.5 as follows:

(40 ILCS 5/15-139.5)

Sec. 15-139.5. Return to work by affected annuitant; notice and contribution by employer.

(a) An employer who employs or re-employs a person receiving a retirement annuity from the System in an academic year beginning on or after August 1, 2013 must notify the System of that employment within 60 days after employing the annuitant. The notice must include a summary of the contract of employment or specify the rate of compensation and the anticipated length of employment of that annuitant. The notice must specify whether the annuitant will be compensated from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name. The notice must include the employer's determination of whether or not the annuitant is an "affected annuitant" as defined in subsection (b).

The employer must also record, document, and certify to the System (i) the amount of compensation paid to the annuitant for employment during the academic year, and (ii) the amount of that compensation, if any, that comes from either federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name.

As used in this Section, "academic year" means the 12-month period beginning September 1.

For the purposes of this Section, an annuitant whose employment by an employer extends over more than one academic year shall be deemed to be re-employed by that employer in each of those academic years.

The System may specify the time, form, and manner of providing the determinations, notifications, certifications, and documentation required under this Section.

(b) A person receiving a retirement annuity from the System becomes an "affected annuitant" on the first day of the academic year following the academic year in which the annuitant first meets the following conditions:

(1) (Blank).

(2) While receiving a retirement annuity under this Article, the annuitant was employed on or after August 1, 2013 by one or more employers under this Article and received or became entitled to receive during an academic year compensation for that employment in excess of 40% of his or her highest annual earnings prior to retirement; except that compensation paid from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name is excluded.

(3) The annuitant received an annualized retirement annuity under this Article of at least $10,000.

A person who becomes an affected annuitant remains an affected annuitant, except for (i) any period during which the person returns to active service and does not receive a retirement annuity from the System or (ii) any period on or after the effective date of this amendatory Act of the 100th General Assembly during which an annuitant received an annualized retirement annuity under this Article that is less than $10,000.

(c) It is the obligation of the employer to determine whether an annuitant is an affected annuitant before employing the annuitant. For that purpose the employer may require the annuitant to disclose and document his or her relevant prior employment and earnings history. Failure of the employer to make this determination correctly and in a timely manner or to include this determination with the notification required under subsection (a) does not excuse the employer from making the contribution required under subsection (e).

The System may assist the employer in determining whether a person is an affected annuitant. The System shall inform the employer if it discovers that the employer's determination is inconsistent with the employment and earnings information in the System's records.

(d) Upon the request of an annuitant, the System shall certify to the annuitant or the employer the following information as reported by the employers, as that information is indicated in the records of the System: (i) the annuitant's highest annual earnings prior to retirement, (ii) the compensation paid for that employment in each academic year, and (iii) whether any of that employment or compensation has been certified to the System as being paid from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name. The System shall only be required to certify information that is received from the employers.

(e) In addition to the requirements of subsection (a), an employer who employs an affected annuitant must pay to the System an employer contribution in the amount and manner provided in this Section, unless the annuitant is compensated by that employer solely from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name.

The employer contribution required under this Section for employment of an affected annuitant in an academic year shall be equal to 12 times the amount of the gross monthly retirement annuity payable to the

annuitant for the month in which the first paid day of that employment in that academic year occurs, after any reduction in that annuity that may be imposed under subsection (b) of Section 15-139.

If an affected annuitant is employed by more than one employer in an academic year, the employer contribution required under this Section shall be divided among those employers in proportion to their respective portions of the total compensation paid to the affected annuitant for that employment during that academic year.

If the System determines that an employer, without reasonable justification, has failed to make the determination of affected annuitant status correctly and in a timely manner, or has failed to notify the System or to correctly document or certify to the System any of the information required by this Section, and that failure results in a delayed determination by the System that a contribution is payable under this Section, then the amount of that employer's contribution otherwise determined under this Section shall be doubled.

The System shall deem a failure to correctly determine the annuitant's status to be justified if the employer establishes to the System's satisfaction that the employer, after due diligence, made an erroneous determination that the annuitant was not an affected annuitant due to reasonable reliance on false or misleading information provided by the annuitant or another employer, or an error in the annuitant's official employment or earnings records.

(f) Whenever the System determines that an employer is liable for a contribution under this Section, it shall so notify the employer and certify the amount of the contribution. The employer may pay the required contribution without interest at any time within one year after receipt of the certification. If the employer fails to pay within that year, then interest shall be charged at a rate equal to the System's prescribed rate of interest, compounded annually from the 366th day after receipt of the certification from the System. Payment must be concluded within 2 years after receipt of the certification by the employer. If the employer fails to make complete payment, including applicable interest, within 2 years, then the System may, after giving notice to the employer, certify the delinquent amount to the State Comptroller, and the Comptroller shall thereupon deduct the certified delinquent amount from State funds payable to the employer and pay them instead to the System.

(g) If an employer is required to make a contribution to the System as a result of employing an affected annuitant and the annuitant later elects to forgo his or her annuity in that same academic year pursuant to subsection (c) of Section 15-139, then the required contribution by the employer shall be waived, and if the contribution has already been paid, it shall be refunded to the employer without interest.

(h) Notwithstanding any other provision of this Article, the employer contribution required under this Section shall not be included in the determination of any benefit under this Article or any other Article of this Code, regardless of whether the annuitant returns to active service, and is in addition to any other State or employer contribution required under this Article.

(i) Notwithstanding any other provision of this Section to the contrary, if an employer employs an affected annuitant in order to continue critical operations in the event of either an employee's unforeseen illness, accident, or death or a catastrophic incident or disaster, then, for one and only one academic year, the employer is not required to pay the contribution set forth in this Section for that annuitant. The employer shall, however, immediately notify the System upon employing a person subject to this subsection (i). For the purposes of this subsection (i), "critical operations" means teaching services, medical services, student welfare services, and any other services that are critical to the mission of the employer.

(i-5) An employer that is liable for aggregate contributions under this Section in excess of $300,000 for employing the same affected annuitant during academic years 2021, 2022, and 2023 shall receive a credit for said contributions made by the employer against future contributions or penalties owed to the System by the employer.

(j) This Section shall be applied and coordinated with the regulatory obligations contained in the State Universities Civil Service Act. This Section shall not apply to an annuitant if the employer of that annuitant provides documentation to the System that (1) the annuitant is employed in a status appointment position, as that term is defined in 80 Ill. Adm. Code 250.80, and (2) due to obligations contained under the State Universities Civil Service Act, the employer does not have the ability to limit the earnings or duration of employment for the annuitant while employed in the status appointment position.

(Source: P.A. 100-556, eff. 12-8-17.)

Article 99.

Section 99-90. The State Mandates Act is amended by adding Section 8.49 as follows:
(30 ILCS 805/8.49 new)
Sec. 8.49. Exempt mandate. Notwithstanding Sections 6 and 8 of this Act, no reimbursement by the State is required for the implementation of any mandate created by this amendatory Act of the 104th General Assembly.

Section 99-99. Effective date. This Article and Articles 1, 9, 11, 12, 15, 26, 33, 34, and 35 take effect upon becoming law.".

The motion prevailed.
And the amendment was adopted and ordered printed.
Senator Martwick offered the following amendment and moved its adoption:

AMENDMENT NO. 3 TO HOUSE BILL 3193

AMENDMENT NO. 3 . Amend House Bill 3193, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 2, on page 211, immediately below line 5, by inserting the following:

"Article 36.

Section 36-5. The Illinois Pension Code is amended by changing Section 7-132 as follows:
(40 ILCS 5/7-132) (from Ch. 108 1/2, par. 7-132)
Sec. 7-132. Municipalities, instrumentalities and participating instrumentalities included and effective dates.

(A) Municipalities and their instrumentalities.

(a) The following described municipalities, but not including any with more than 1,000,000 inhabitants, and the instrumentalities thereof, shall be included within and be subject to this Article beginning upon the effective dates specified by the Board:

(1) Except as to the municipalities and instrumentalities thereof specifically excluded under this Article, every county shall be subject to this Article, and all cities, villages and incorporated towns having a population in excess of 5,000 inhabitants as determined by the last preceding decennial or subsequent federal census, shall be subject to this Article following publication of the census by the Bureau of the Census. Within 90 days after publication of the census, the Board shall notify any municipality that has become subject to this Article as a result of that census, and shall provide information to the corporate authorities of the municipality explaining the duties and consequences of participation. The notification shall also include a proposed date upon which participation by the municipality will commence.

However, for any city, village or incorporated town that attains a population over 5,000 inhabitants after having provided social security coverage for its employees under the Social Security Enabling Act, participation under this Article shall not be mandatory but may be elected in accordance with subparagraph (3) or (4) of this paragraph (a), whichever is applicable.

(2) School districts, other than those specifically excluded under this Article, shall be subject to this Article, without election, with respect to all employees thereof.

(3) Towns and all other bodies politic and corporate which are formed by vote of, or are subject to control by, the electors in towns and are located in towns which are not participating municipalities on the effective date of this Act, may become subject to this Article by election pursuant to Section 7-132.1.

(4) Any other municipality (together with its instrumentalities), other than those specifically excluded from participation and those described in paragraph (3) above, may elect to be included either by referendum under Section 7-134 or by the adoption of a resolution or ordinance by its governing body. A copy of such resolution or ordinance duly authenticated and certified by the clerk of the municipality or other appropriate official of its governing body shall constitute the required notice to the board of such action.

(b) A municipality that is about to begin participation shall submit to the Board an application to participate, in a form acceptable to the Board, not later than 90 days prior to the proposed effective date of

participation. The Board shall act upon the application within 90 days, and if it finds that the application is in conformity with its requirements and the requirements of this Article, participation by the applicant shall commence on a date acceptable to the municipality and specified by the Board, but in no event more than one year from the date of application.

(c) A participating municipality which succeeds to the functions of a participating municipality which is dissolved or terminates its existence shall assume and be transferred the net accumulation balance in the municipality reserve and the municipality account receivable balance of the terminated municipality.

(d) In the case of a Veterans Assistance Commission whose employees were being treated by the Fund on January 1, 1990 as employees of the county served by the Commission, the Fund may continue to treat the employees of the Veterans Assistance Commission as county employees for the purposes of this Article, unless the Commission becomes a participating instrumentality in accordance with subsection (B) of this Section.

(B) Participating instrumentalities.

(a) The participating instrumentalities designated in paragraph (b) of this subsection shall be included within and be subject to this Article if:

(1) an application to participate, in a form acceptable to the Board and adopted by a two-thirds vote of the governing body, is presented to the Board not later than 90 days prior to the proposed effective date; and

(2) the Board finds that the application is in conformity with its requirements, that the applicant has reasonable expectation to continue as a political entity for a period of at least 10 years and has the prospective financial capacity to meet its current and future obligations to the Fund, and that the actuarial soundness of the Fund may be reasonably expected to be unimpaired by approval of participation by the applicant.

The Board shall notify the applicant of its findings within 90 days after receiving the application, and if the Board approves the application, participation by the applicant shall commence on the effective date specified by the Board.

(b) The following participating instrumentalities, so long as they meet the requirements of Section 7-108 and the area served by them or within their jurisdiction is not located entirely within a municipality having more than one million inhabitants, may be included hereunder:

i. Township School District Trustees.

ii. Multiple County and Consolidated Health Departments created under Division 5-25 of the Counties Code or its predecessor law.

iii. Public Building Commissions created under the Public Building Commission Act, and located in counties of less than 1,000,000 inhabitants.

iv. A multitype, consolidated or cooperative library system created under the Illinois Library System Act. Any library system created under the Illinois Library System Act that has one or more predecessors that participated in the Fund may participate in the Fund upon application. The Board shall establish procedures for implementing the transfer of rights and obligations from the predecessor system to the successor system.

v. Regional Planning Commissions created under Division 5-14 of the Counties Code or its predecessor law.

vi. Local Public Housing Authorities created under the Housing Authorities Act, located in counties of less than 1,000,000 inhabitants.

vii. Illinois Municipal League.

viii. Northeastern Illinois Metropolitan Area Planning Commission.

ix. Southwestern Illinois Metropolitan Area Planning Commission.

x. Illinois Association of Park Districts.

xi. Illinois Supervisors, County Commissioners and Superintendents of Highways Association.

xii. Tri-City Regional Port District.

xiii. An association, or not-for-profit corporation, membership in which is authorized under Section 85-15 of the Township Code.

xiv. Drainage Districts operating under the Illinois Drainage Code.

xv. Local mass transit districts created under the Local Mass Transit District Act.

xvi. Soil and water conservation districts created under the Soil and Water Conservation Districts Law.

xvii. Commissions created to provide water supply or sewer services or both under Division 135 or Division 136 of Article 11 of the Illinois Municipal Code.

xviii. Public water districts created under the Public Water District Act.

xix. Veterans Assistance Commissions established under Section 9 of the Military Veterans Assistance Act that serve counties with a population of less than 1,000,000.

xx. The governing body of an entity, other than a vocational education cooperative, created under an intergovernmental cooperative agreement established between participating municipalities under the Intergovernmental Cooperation Act, which by the terms of the agreement is the employer of the persons performing services under the agreement under the usual common law rules determining the employer-employee relationship. The governing body of such an intergovernmental cooperative entity established prior to July 1, 1988 may make participation retroactive to the effective date of the agreement and, if so, the effective date of participation shall be the date the required application is filed with the fund. If any such entity is unable to pay the required employer contributions to the fund, then the participating municipalities shall make payment of the required contributions and the payments shall be allocated as provided in the agreement or, if not so provided, equally among them.

xxi. The Illinois Municipal Electric Agency.

xxii. The Waukegan Port District.

xxiii. The Fox Waterway Agency created under the Fox Waterway Agency Act.

xxiv. The Illinois Municipal Gas Agency.

xxv. The Kaskaskia Regional Port District.

xxvi. The Southwestern Illinois Development Authority.

xxvii. The Cairo Public Utility Company.

xxviii. Except with respect to employees who elect to participate in the State Employees' Retirement System of Illinois under Section 14-104.13 of this Code, the Chicago Metropolitan Agency for Planning created under the Regional Planning Act, provided that, with respect to the benefits payable pursuant to Sections 7-146, 7-150, and 7-164 and the requirement that eligibility for such benefits is conditional upon satisfying a minimum period of service or a minimum contribution, any employee of the Chicago Metropolitan Agency for Planning that was immediately prior to such employment an employee of the Chicago Area Transportation Study or the Northeastern Illinois Planning Commission, such employee's service at the Chicago Area Transportation Study or the Northeastern Illinois Planning Commission and contributions to the State Employees' Retirement System of Illinois established under Article 14 and the Illinois Municipal Retirement Fund shall count towards the satisfaction of such requirements.

xxix. United Counties Council (formerly the Urban Counties Council), but only if the Council has a ruling from the United States Internal Revenue Service that it is a governmental entity.

xxx. The Will County Governmental League, but only if the League has a ruling from the United States Internal Revenue Service that it is a governmental entity.

xxxi. The Firefighters' Pension Investment Fund.

xxxii. The Police Officers' Pension Investment Fund.

xxxiii. The Joliet Regional Port District.

(c) The governing boards of special education joint agreements created under Section 10-22.31 of the School Code without designation of an administrative district shall be included within and be subject to this Article as participating instrumentalities when the joint agreement becomes effective. However, the governing board of any such special education joint agreement in effect before September 5, 1975 shall not be subject to this Article unless the joint agreement is modified by the school districts to provide that the governing board is subject to this Article, except as otherwise provided by this Section.

The governing board of the Special Education District of Lake County shall become subject to this Article as a participating instrumentality on July 1, 1997. Notwithstanding subdivision (a)1 of Section 7-139, on the effective date of participation, employees of the governing board of the Special Education District of Lake County shall receive creditable service for their prior service with that employer, up to a maximum of 5 years, without any employee contribution. Employees may establish creditable service for the remainder of their prior service with that employer, if any, by applying in writing and paying an employee contribution in an amount determined by the Fund, based on the employee contribution rates in effect at the time of application for the creditable service and the employee's salary rate on the effective date of participation for that employer, plus interest at the effective rate from the date of the prior service to the date of payment. Application for this creditable service must be made before July 1, 1998; the payment may

be made at any time while the employee is still in service. The employer may elect to make the required contribution on behalf of the employee.

The governing board of a special education joint agreement created under Section 10-22.31 of the School Code for which an administrative district has been designated, if there are employees of the cooperative educational entity who are not employees of the administrative district, may elect to participate in the Fund and be included within this Article as a participating instrumentality, subject to such application procedures and rules as the Board may prescribe.

The Boards of Control of cooperative or joint educational programs or projects created and administered under Section 3-15.14 of the School Code, whether or not the Boards act as their own administrative district, shall be included within and be subject to this Article as participating instrumentalities when the agreement establishing the cooperative or joint educational program or project becomes effective.

The governing board of a special education joint agreement entered into after June 30, 1984 and prior to September 17, 1985 which provides for representation on the governing board by less than all the participating districts shall be included within and subject to this Article as a participating instrumentality. Such participation shall be effective as of the date the joint agreement becomes effective.

The governing boards of educational service centers established under Section 2-3.62 of the School Code shall be included within and subject to this Article as participating instrumentalities. The governing boards of vocational education cooperative agreements created under the Intergovernmental Cooperation Act and approved by the State Board of Education shall be included within and be subject to this Article as participating instrumentalities. If any such governing boards or boards of control are unable to pay the required employer contributions to the fund, then the school districts served by such boards shall make payment of required contributions as provided in Section 7-172. The payments shall be allocated among the several school districts in proportion to the number of students in average daily attendance for the last full school year for each district in relation to the total number of students in average attendance for such period for all districts served. If such educational service centers, vocational education cooperatives or cooperative or joint educational programs or projects created and administered under Section 3-15.14 of the School Code are dissolved, the assets and obligations shall be distributed among the districts in the same proportions unless otherwise provided.

The governing board of Paris Cooperative High School shall be included within and be subject to this Article as a participating instrumentality on the effective date of this amendatory Act of the 96th General Assembly. If the governing board of Paris Cooperative High School is unable to pay the required employer contributions to the fund, then the school districts served shall make payment of required contributions as provided in Section 7-172. The payments shall be allocated among the several school districts in proportion to the number of students in average daily attendance for the last full school year for each district in relation to the total number of students in average attendance for such period for all districts served. If Paris Cooperative High School is dissolved, then the assets and obligations shall be distributed among the districts in the same proportions unless otherwise provided.

The Philip J. Rock Center and School shall be included within and be subject to this Article as a participating instrumentality on the effective date of this amendatory Act of the 97th General Assembly. The Philip J. Rock Center and School shall certify to the Fund the dates of service of all employees within 90 days of the effective date of this amendatory Act of the 97th General Assembly. The Fund shall transfer to the IMRF account of the Philip J. Rock Center and School all creditable service and all employer contributions made on behalf of the employees for service at the Philip J. Rock Center and School that were reported and paid to IMRF by another employer prior to this date. If the Philip J. Rock Center and School is unable to pay the required employer contributions to the Fund, then the amount due will be paid by all employers as defined in item (2) of paragraph (a) of subsection (A) of this Section. The payments shall be allocated among these employers in proportion to the number of students in average daily attendance for the last full school year for each district in relation to the total number of students in average attendance for such period for all districts. If the Philip J. Rock Center and School is dissolved, then its IMRF assets and obligations shall be distributed in the same proportions unless otherwise provided.

Financial Oversight Panels established under Article 1H of the School Code shall be included within and be subject to this Article as a participating instrumentality on the effective date of this amendatory Act of the 97th General Assembly. If the Financial Oversight Panel is unable to pay the required employer contributions to the fund, then the school districts served shall make payment of required contributions as

provided in Section 7-172. If the Financial Oversight Panel is dissolved, then the assets and obligations shall be distributed to the district served.

(d) The governing boards of special recreation joint agreements created under Section 8-10b of the Park District Code, operating without designation of an administrative district or an administrative municipality appointed to administer the program operating under the authority of such joint agreement shall be included within and be subject to this Article as participating instrumentalities when the joint agreement becomes effective. However, the governing board of any such special recreation joint agreement in effect before January 1, 1980 shall not be subject to this Article unless the joint agreement is modified, by the districts and municipalities which are parties to the agreement, to provide that the governing board is subject to this Article.

If the Board returns any employer and employee contributions to any employer which erroneously submitted such contributions on behalf of a special recreation joint agreement, the Board shall include interest computed from the end of each year to the date of payment, not compounded, at the rate of 7% per annum.

(e) Each multi-township assessment district, the board of trustees of which has adopted this Article by ordinance prior to April 1, 1982, shall be a participating instrumentality included within and subject to this Article effective December 1, 1981. The contributions required under Section 7-172 shall be included in the budget prepared under and allocated in accordance with Section 2-30 of the Property Tax Code.

(f) The Illinois Medical District Commission created under the Illinois Medical District Act may be included within and subject to this Article as a participating instrumentality, notwithstanding that the location of the District is entirely within the City of Chicago. To become a participating instrumentality, the Commission must apply to the Board in the manner set forth in paragraph (a) of this subsection (B). If the Board approves the application, under the criteria and procedures set forth in paragraph (a) and any other applicable rules, criteria, and procedures of the Board, participation by the Commission shall commence on the effective date specified by the Board.

(C) Prospective participants.

Beginning January 1, 1992, each prospective participating municipality or participating instrumentality shall pay to the Fund the cost, as determined by the Board, of a study prepared by the Fund or its actuary, detailing the prospective costs of participation in the Fund to be expected by the municipality or instrumentality.

(Source: P.A. 102-637, eff. 8-27-21.)"; and

on page 211, line 15, by replacing "and 35" with "35, and 36".

The motion prevailed.

And the amendment was adopted and ordered printed.

Senator Martwick offered the following amendment and moved its adoption:

AMENDMENT NO. 4 TO HOUSE BILL 3193

AMENDMENT NO. 4 . Amend House Bill 3193, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 2, on page 20, by replacing lines 7 through 23 with the following:

"(40 ILCS 5/1-107) (from Ch. 108 1/2, par. 1-107)

Sec. 1-107. Indemnification of trustees, consultants, and employees of retirement systems and pension funds. Every retirement system, pension fund, or other system or fund established under this Code shall ~~may~~ indemnify and protect the trustees and~~,~~ staff ~~and consultants~~ against all damage claims and suits, including the defense thereof, when damages are sought for negligent or wrongful acts alleged to have been committed in the scope of employment or under the direction of the trustees. Every retirement system, pension fund, or other system or fund established under this Code may indemnify and protect its consultants against all damage claims and suits, including the defense thereof, when damages are sought for negligent or wrongful acts alleged to have been committed in the scope of employment or under the direction of the trustees. However, the trustees, staff, and consultants shall not be indemnified for willful ~~wilful~~ misconduct and gross negligence. Each board is authorized to insure against loss or liability of the trustees, staff and

consultants which may result from these damage claims. This insurance shall be carried in a company which is licensed to write such coverage in this State.
(Source: P.A. 80-1364.)"; and

on page 121, by deleting lines 10 through 20.

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.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Martwick, **House Bill No. 3193** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 57; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Wilcox
Curran	Holmes	Rezin	Mr. President
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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 in the Senate Amendments adopted thereto.

HOUSE BILL RECALLED

On motion of Senator Koehler, **House Bill No. 1697** was recalled from the order of third reading to the order of second reading.

Senator Koehler offered the following amendment and moved its adoption:

AMENDMENT NO. 2 TO HOUSE BILL 1697

AMENDMENT NO. 2 . Amend House Bill 1697, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. This Act may be referred to as the Prescription Drug Affordability Act.

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

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.2, 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.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, 356z.76, and 356z.77 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Section 356m of the Illinois Insurance Code and, for the employees of the State Employee Group Insurance Program only, the coverage as also provided in Section 6.11B of this Act. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 and Article XXXIIB of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

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

(Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-768, eff. 1-1-24; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-8, eff. 1-1-24; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-870, eff. 1-1-25; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-951, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 10. The Department of Commerce and Economic Opportunity Law of the Civil Administrative Code of Illinois is amended by changing Section 605-60 as follows:

(20 ILCS 605/605-60)

Sec. 605-60. DCEO Projects Fund.

(a) The DCEO Projects Fund is created as a trust fund in the State treasury. The Department is authorized to accept and deposit into the Fund moneys received from any gifts, grants, transfers, or other sources, public or private, unless deposit into a different fund is otherwise mandated.

(b) Subject to appropriation, the Department shall use moneys in the Fund to make grants or loans to and enter into contracts with units of local government, local and regional economic development corporations, retail associations, and not-for-profit organizations for municipal development projects, for the specific purposes established by the terms and conditions of the gift, grant, or award, and for related administrative expenses. As used in this Section, the term "municipal development projects" includes, but is not limited to, grants for reducing food insecurity in urban and rural areas.

(c) In this subsection, "rural tract" and "urban tract" have the meanings given to those terms in Section 5 of the Grocery Initiative Act.

Subject to appropriation, the Department shall use moneys deposited into the Fund pursuant to Section 513b2 of the Illinois Insurance Code to make a grant to a statewide retail association representing pharmacies to promote access to pharmacies and pharmacist services. Grant funds under this subsection shall be made available to the following beneficiaries:

(1) critical access care pharmacies as defined in Section 5-5.12b of the Illinois Public Aid Code;

(2) retail pharmacies with a physical location in Illinois owned by a person or entity with an ownership or control interest in fewer than 10 pharmacies;

(3) retail pharmacies with a physical location in a county in Illinois with fewer than 50,000 residents;

(4) retail pharmacies with a physical location in a county in Illinois with 50,000 or more residents and in an area within Illinois that is designated by the United States Department of Health and Human Services as either: (A) a Medically Underserved Area, including Governor's Exceptions; or (B) a Medically Underserved Population, including Governor's Exceptions;

(5) pharmacies whose claims constitute 65% or greater for Medicaid services and at least 80% of their total claims are for pharmacy services administered in Illinois;

(6) a pharmacy located in an Illinois census tract that meets both of the following poverty and population density and pharmacy accessibility standards:

(A) the census tract has either: (i) 20% or more of its population living below 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); or (ii) a median household income of less than 80% of the median income of the nearest metropolitan area; and

(B) the census tract has at least 33% of its population living one mile or more from the pharmacy for urban tracts or more than 10 miles from the pharmacy for rural tracts.

At least annually, the Department shall file with the Governor and the General Assembly a report that includes:

(1) the number of beneficiaries who applied for funding;

(2) the number of beneficiaries who received funding; and

(3) the pharmacies that were awarded funding, including the location, the amount of funding, and the subsection category or categories under which the pharmacy qualified.

(Source: P.A. 103-588, eff. 6-5-24.)

Section 12. The State Finance Act is amended by adding Section 5.1030 as follows:

(30 ILCS 105/5.1030 new)

Sec. 5.1030. The Prescription Drug Affordability Fund.

Section 15. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, and 356z.77 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, and 370c and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

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; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, 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; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 20. The Illinois Insurance Code is amended by changing Sections 513b1, 513b2, and 513b3 and by adding Section 513b1.1 as follows:

(215 ILCS 5/513b1)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this Section:

"340B drug discount program" means the program established under Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b.

"340B entity" means a covered entity as defined in 42 U.S.C. 256b(a)(4) authorized to participate in the 340B drug discount program.

"340B pharmacy" means any pharmacy used to dispense 340B drugs for a covered entity, whether entity-owned or external.

"Affiliate" means a person or entity that directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, the person or entity specified. The location of a person or entity's domicile, whether in Illinois or a foreign or alien jurisdiction, does not affect the person or entity's status as an affiliate.

"Biological product" has the meaning ascribed to that term in Section 19.5 of the Pharmacy Practice Act.

"Brand name drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed under a proprietary, trademark-protected name.

"Complex or chronic medical condition" means a physical, behavioral, or developmental condition that has no known cure, is progressive, or can be debilitating or fatal if unmanaged or untreated.

"Covered individual" means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a health benefit plan who is provided a drug benefit by the health benefit plan.

"Critical access pharmacy" means a critical access care pharmacy as defined in Section 5-5.12b of the Illinois Public Aid Code.

"Drugs" has the meaning ascribed to that term in Section 3 of the Pharmacy Practice Act and includes biological products.

"Generic drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed directly or indirectly to the retail class of trade with labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trademark that differs from that of the brand name drug.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of physical, mental, or behavioral health care services. Notwithstanding Sections 122-1 through 122-4 of this Code, "health benefit plan" includes self-funded employee welfare benefit plans. Notwithstanding Sections 122-1 through 122-4 of this Code, "health benefit plan" includes self-funded employee welfare benefit plans except for self-funded multiemployer plans that are not nonfederal government plans.

"Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

"Maximum allowable cost list" means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.

"Pharmacy benefit manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other ~~prescription~~ drug or device services, or both, for health benefit plans.

"Pharmacy" has the meaning given to that term in Section 3 of the Pharmacy Practice Act.

"Pharmacy services" means the provision of any services listed within the definition of "practice of pharmacy" under subsection (d) of Section 3 of the Pharmacy Practice Act.

"Rare medical condition" means a physical, behavioral, or developmental condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide.

"Rebate" means a discount or pricing concession based on drug utilization or administration that is paid by the manufacturer to a pharmacy benefit manager or its client.

"Rebate aggregator" means a person or entity, including group purchasing organizations, that negotiate rebates or other fees with drug manufacturers on behalf or for the benefit of a pharmacy benefit manager or its client and may also be involved in contracts that entitle the rebate aggregator or its client to receive rebates or other fees from drug manufacturers based on drug utilization or administration.

"Retail price" means the price an individual without ~~prescription~~ drug coverage would pay at a retail pharmacy, not including a pharmacist dispensing fee.

"Specialty drug" means a drug that:

(1) is prescribed for a person with a complex or chronic medical condition or a rare medical condition;

(2) has limited or exclusive distribution; and

(3) requires both:

(A) specialized product handling by the dispensing pharmacy or administration by the dispensing pharmacy; and

(B) specialized clinical care, including frequent dosing adjustments, intensive clinical monitoring, or expanded services for patients, including intensive patient counseling, education, or ongoing clinical support beyond traditional dispensing activities, such as individualized disease and therapy management to support improved health outcomes.

"Spread pricing" means the model of drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for drugs, and the contracted price for the drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for the drugs, pharmacist services, or drug and dispensing fees.

"Steer" includes, but is not limited to:

(1) requiring a covered individual to only use a pharmacy, including a mail-order or specialty pharmacy, in which the pharmacy benefit manager or its affiliate maintains an ownership interest or control;

(2) offering or implementing a plan design that encourages a covered individual to only use a pharmacy in which the pharmacy benefit manager or an affiliate maintains an ownership interest or control, if the plan design increases costs for the covered individual. This includes a plan design that requires a covered individual to pay higher costs or an increased share of costs for a drug or drug-related service if the covered individual uses a pharmacy that is not owned or controlled by the pharmacy benefit manager or its affiliate.

(3) reimbursing a pharmacy or pharmacist for a drug and pharmacist service in an amount less than the amount that the pharmacy benefit manager reimburses itself or an affiliate, including affiliated manufacturers or joint ventures for providing the same drug or service.

"Third-party payer" means any entity that pays for ~~prescription~~ drugs on behalf of a patient other than a health care provider or sponsor of a plan subject to regulation under Medicare Part D, 42 U.S.C. 1395w-101 et seq.

(a-5) In this Article, references to an "insurer" or "health insurer" shall include commercial private health insurance issuers, managed care organizations, managed care community networks, and any other third-party payer that contracts with pharmacy benefit managers or with the Department of Healthcare and Family Services to provide benefits or services under the Medicaid program or to otherwise engage in the administration or payment of pharmacy benefits. However, the terms do not refer to the plan sponsor of a self-funded, single-employer employee welfare benefit plan or self-funded multiemployer plan subject to 29 U.S.C. 1144.

(b) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(1) Update maximum allowable cost pricing information at least every 7 calendar days.

(2) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) Provide access to its maximum allowable cost list to each pharmacy or pharmacy services administrative organization subject to the maximum allowable cost list. Access may include a real-time pharmacy website portal to be able to view the maximum allowable cost list. As used in this Section, "pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers. A pharmacy services administrative organization may provide administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies.

(4) Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. The appeals process must, at a minimum, include the following:

(A) A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug.

(B) A requirement that a pharmacy benefit manager must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted.

(C) A telephone number and e-mail address or website to network providers, at which the provider can contact the pharmacy benefit manager to process and submit an appeal.

(D) A requirement that, if an appeal is denied, the pharmacy benefit manager must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers.

(E) A requirement that, if an appeal is sustained, the pharmacy benefit manager must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager.

(5) Allow a plan sponsor or insurer whose coverage is administered by the ~~contracting with a~~ pharmacy benefit manager an annual right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any and all rebate amounts secured, whether product specific or generalized rebates, that were provided to the pharmacy benefit manager by a pharmaceutical manufacturer. The cost of the audit shall be borne exclusively by the pharmacy benefit manager.

(6) Allow a plan sponsor or insurer whose coverage is administered by the ~~contracting with a~~ pharmacy benefit manager to request that the pharmacy benefit manager disclose the actual amounts paid by the pharmacy benefit manager to the pharmacy.

(7) Provide notice to the plan sponsor or the insurer party contracting with the pharmacy benefit manager of any consideration that the pharmacy benefit manager receives from the manufacturer for dispense as written ~~prescriptions~~ once a generic or biologically similar product becomes available.

(c) In order to place a particular ~~prescription~~ drug on a maximum allowable cost list, the pharmacy benefit manager must, at a minimum, ensure that:

(1) if the drug is a generically equivalent drug, it is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;

(2) the drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and

(3) the drug is not obsolete.

(d) A pharmacy benefit manager is prohibited from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered ~~prescription~~ drug, and the availability of a more affordable alternative drug, if one is available in accordance with Section 42 of the Pharmacy Practice Act.

(e) A health insurer or pharmacy benefit manager shall not require a covered individual ~~an insured~~ to make a payment for a ~~prescription~~ drug at the point of sale in an amount that exceeds the lesser of:

(1) the applicable cost-sharing amount; ~~or~~

(2) the retail price of the drug in the absence of ~~prescription~~ drug coverage;

(3) the discounted price presented by the covered individual through a no-cost drug program or drug manufacturer voucher provided by or for the covered individual at the point of sale; or

(4) the discounted price presented by the covered individual through a discounted health care services plan provided by or for the covered individual at the point of sale.

(f) Unless required by law, a contract between a pharmacy benefit manager or third-party payer and a 340B entity or 340B pharmacy shall not contain any provision that:

(1) distinguishes between drugs purchased through the 340B drug discount program and other drugs when determining reimbursement or reimbursement methodologies, or contains otherwise less favorable payment terms or reimbursement methodologies for 340B entities or 340B pharmacies when compared to similarly situated non-340B entities;

(2) imposes any fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(3) imposes any fee, chargeback, or rate adjustment that exceeds the fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(4) prevents or interferes with an individual's choice to receive a covered ~~prescription~~ drug from a 340B entity or 340B pharmacy through any legally permissible means, except that nothing in this paragraph shall prohibit the establishment of differing copayments or other cost-sharing amounts

within the health benefit plan for covered individuals ~~persons~~ who acquire covered ~~prescription~~ drugs from a nonpreferred or nonparticipating provider;

(5) excludes a 340B entity or 340B pharmacy from a pharmacy network on any basis that includes consideration of whether the 340B entity or 340B pharmacy participates in the 340B drug discount program;

(6) prevents a 340B entity or 340B pharmacy from using a drug purchased under the 340B drug discount program; or

(7) any other provision that discriminates against a 340B entity or 340B pharmacy by treating the 340B entity or 340B pharmacy differently than non-340B entities or non-340B pharmacies for any reason relating to the entity's participation in the 340B drug discount program.

As used in this subsection, "pharmacy benefit manager" and "third-party payer" do not include pharmacy benefit managers and third-party payers acting on behalf of a Medicaid program.

(f-5) A pharmacy benefit manager or an affiliate acting on its behalf shall not conduct spread pricing.

(f-10) A pharmacy benefit manager or an affiliate acting on its behalf shall not steer a covered individual. Existing agreements entered into before the effective date of this amendatory Act of the 104th General Assembly shall supersede this subsection until the termination of the current term of such agreement.

(f-15) A pharmacy benefit manager or affiliated rebate aggregator must remit no less than 100% of any amounts paid by a pharmaceutical manufacturer, wholesaler, or other distributor of a drug, including, but not limited to, rebates, group purchasing fees, and other fees, to the health benefit plan sponsor, covered individual, or employer. Records of rebates and fees remitted from the pharmacy benefit manager or rebate aggregator must be disclosed to the Department annually in a format to be specified by the Department. The records received by the Department shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(f-20) A pharmacy benefit manager or an affiliate acting on its behalf is prohibited from limiting a covered individual's access to drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by designating the covered drug as a specialty drug contrary to the definition in this Section.

(f-25) The contract between the pharmacy benefit manager and the insurer or health benefit plan sponsor must allow and provide for the pharmacy benefit manager's compliance with an audit at least once per calendar year of the rebate and fee records remitted from a pharmacy benefit manager or its affiliated party to a health benefit plan. This audit may be incorporated into the audit under paragraph (5) of subsection (b) of this Section. Contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers must be available for audit by health benefit plan sponsors, insurers, or their designees at least once per plan year. Audits shall be performed by an auditor selected by the health benefit plan sponsor, insurer, or its designee. Health benefit plan sponsors and insurers shall give the pharmacy benefit manager a complete copy of the audit and the pharmacy benefit manager shall provide a complete copy of those findings to the Department within 60 days of initial receipt. Rebate contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers shall be available for audit by health benefit plan sponsor, insurer, or designee. Nothing in this Section shall limit the Department's ability to access the books and records and any and all copies thereof of pharmacy benefit managers, their affiliates, or affiliated rebate aggregators. The records received by the Department shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(g) A violation of this Section by a pharmacy benefit manager constitutes an unfair or deceptive act or practice in the business of insurance under Section 424.

(h) A provision that violates subsection (f) in a contract between a pharmacy benefit manager or a third-party payer and a 340B entity that is entered into, amended, or renewed after July 1, 2022 shall be void and unenforceable. This subsection and subsection (f) do not apply to a contract directly between a 340B entity and the plan sponsor of a self-funded, single-employer employee welfare benefit plan subject to 29 U.S.C. 1144.

(i)(1) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information in a court, in an administrative hearing, before a legislative commission or committee, or in any

other proceeding, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(2) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information to a government or law enforcement agency, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(3) A pharmacist or pharmacy shall make commercially reasonable efforts to limit the disclosure of confidential and proprietary information.

(4) Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has:

(A) made disclosures of information that the pharmacist or pharmacy has reasonable cause to believe is evidence of a violation of a State or federal law, rule, or regulation;

(B) filed complaints with the plan or pharmacy benefit manager; or

(C) filed complaints against the plan or pharmacy benefit manager with the Department.

(j) This Section applies to contracts entered into or renewed on or after July 1, 2022 and, unless provided otherwise in this Section or in the Illinois Public Aid Code, applies to pharmacy benefit managers that are contracted with a Medicaid managed care entity on or after January 1, 2026.

(k) This Section applies to any health benefit ~~group or individual policy of accident and health insurance or managed care~~ plan that provides coverage for ~~prescription~~ drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020. The changes made to this Section by this amendatory Act of the 104th General Assembly shall apply with respect to any health benefit plan that provides coverage for drugs that is amended, delivered, issued, or renewed on or after January 1, 2026.

(l) A pharmacy benefit manager is responsible for compliance with all State requirements applicable to pharmacy benefit managers even if an action or responsibility of a pharmacy benefit manager is delegated to or completed by an affiliate.

(Source: P.A. 102-778, eff. 7-1-22; 103-154, eff. 6-30-23; 103-453, eff. 8-4-23.)

(215 ILCS 5/513b1.1 new)

Sec. 513b1.1. Pharmacy benefit manager reporting requirements.

(a) A pharmacy benefit manager that provides services for a health benefit plan must submit an annual report no later than September 1, to the Department, each health benefit plan sponsor, and each insurer that includes the following:

(1) data on the health benefit plan including:

(A) a list of drugs including corresponding information on therapeutic class, brand name, generic name, or specialty drug name;

(B) number of covered individuals;

(C) number of drug-related claims;

(D) dosage units;

(E) dispensing channel used;

(F) average wholesale acquisition cost per drug; and

(G) total out-of-pocket spending by deidentified covered individual per drug, per transaction;

(2) amount received by the health benefit plan in rebates, fees, or discounts related to drug utilization or spending;

(3) total gross spending on drugs by the health benefit plan;

(4) total net spending, gross spending less administrative portion of the medical loss ratio, on drugs by the health benefit plan;

(5) the amount paid by the health benefit plan to the pharmacy benefit manager for reimbursement cost of a drug and service per transaction;

(6) the amount a pharmacy benefit manager paid for pharmacists' services and drugs rendered related to the health benefit plan per transaction, including, but not limited to, any dispensing fee;

(7) the specific rebate amount received by the pharmacy benefit manager per transaction, the amount of the rebates passed through to the health benefit plan per transaction, and the amount of the rebates passed on to covered individuals at the point of sale that reduced the covered individuals' applicable deductible, copayment, coinsurance, or other cost-sharing amount per transaction;

(8) any information collected from drug manufacturers pertaining to copayment assistance to the extent such information is collected;

(9) any compensation paid to brokers, consultants, advisors, or any other individual or firm for referrals, consideration, or retention by the health benefit plan;

(10) explanation of benefit design parameters encouraging or requiring covered individuals to use affiliated pharmacies, percentage of drugs charged by these pharmacies, and a list of drugs dispensed by affiliated pharmacies with their associated costs; and

(11) a complete copy of each unredacted contract the pharmacy benefit manager has with the health benefit plan sponsor or insurer.

(b) Annual reports pursuant to subsection (a):

(1) must be written in plain language to ensure ease of reading and accessibility;

(2) must only contain summary health information to ensure plan, coverage, or covered individual information remains private and confidential;

(3) upon request by a covered individual, must be available in summary format and provide aggregated information to help covered individuals understand their health benefit plan's drug coverage; and

(4) must be filed with the Department no later than September 1 of each year via the Systems for Electronic Rates & Forms Filing (SERFF). The filing shall include the summary version of the report described in paragraph (3) of this subsection, which shall be marked for public access.

The Department may share all reports with an established institution of higher education in this State for the creation of a pharmacist dispensing cost report to be produced annually. This annual pharmacist dispensing cost report shall provide a survey of the average cost of dispensing a prescription for pharmacists in Illinois. The institution of higher education shall have the ability to request additional information from pharmacists for its analysis. The institution of higher education shall issue the report to the General Assembly no later than December 31, 2026 and annually thereafter.

(c) A pharmacy benefit manager may petition the Department for a filing submission extension. The Director may grant or deny the extension within 5 business days.

(d) Failure by a pharmacy benefit manager to submit all required elements in an annual report to the Department may result in a fine levied by the Director not to exceed $10,000 per day, per offense. Funds derived from fines levied shall be deposited into the Insurance Producer Administration Fund. Fine information shall be posted on the Department's website.

(e) A pharmacy benefit manager found in violation of subsection (a) or paragraph (4) of subsection (b) may request a hearing from the Director within 10 days of receipt of the Director's order, or, if the violation is found in a market conduct examination, as provided in Section 132 of this Code.

(f) Except for the summary version, the annual reports submitted by pharmacy benefit managers shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(g) A copy of an adverse decision against a pharmacy benefit manager for failing to submit an annual report to the Department must be posted to the Department's website.

(h) Nothing in this Section shall be construed as permitting a pharmacy benefit manager to avoid or otherwise fail to comply with the reporting requirements set forth in Section 5-36 of the Illinois Public Aid Code.

(215 ILCS 5/513b2)

Sec. 513b2. Licensure requirements.

(a) Beginning on July 1, 2020, to conduct business in this State, a pharmacy benefit manager must register with the Director. To initially register or renew a registration, a pharmacy benefit manager shall submit:

(1) A nonrefundable fee not to exceed $500.

(2) A copy of the registrant's corporate charter, articles of incorporation, or other charter document.

(3) A completed registration form adopted by the Director containing:

(A) The name and address of the registrant.

(B) The name, address, and official position of each officer and director of the registrant.

(b) The registrant shall report any change in information required under this Section to the Director in writing within 60 days after the change occurs.

(c) Upon receipt of a completed registration form, the required documents, and the registration fee, the Director shall issue a registration certificate. The certificate may be in paper or electronic form, and shall clearly indicate the expiration date of the registration. Registration certificates are nontransferable.

(d) A registration certificate is valid for 2 years after its date of issue. The Director shall adopt by rule an initial registration fee not to exceed $500 and a registration renewal fee not to exceed $500, both of which shall be nonrefundable. Total fees may not exceed the cost of administering this Section.

(e) The Department shall adopt any rules necessary to implement this Section.

(f) On or before August 1, 2025, the pharmacy benefit manager shall submit a report to the Department that lists the name of each health benefit plan it administers, provides the number of covered individuals for each health benefit plan as of the date of submission, and provides the total number of covered individuals across all health benefit plans the pharmacy benefit manager administers. On or before September 1, 2025, a registered pharmacy benefit manager, as a condition of its authority to transact business in this State, must submit to the Department an amount equal to $15 or an alternate amount as determined by the Director by rule per covered individual enrolled by the pharmacy benefit manager in this State, as detailed in the report submitted to the Department under this subsection, during the preceding calendar year. On or before September 1, 2026 and each September 1 thereafter, payments submitted under this subsection shall be based on the number of covered individuals reported to the Department in Section 513b1.1.

(g) All amounts collected under this Section shall be deposited into the Prescription Drug Affordability Fund, which is hereby created as a special fund in the State treasury. Of the amounts collected under this Section each fiscal year, the Department shall transfer the first $25,000,000 into the DCEO Projects Fund. Moneys deposited into the Prescription Drug Affordability Fund shall be used to pay the expenses of the Department.

(Source: P.A. 101-452, eff. 1-1-20.)

(215 ILCS 5/513b3)

Sec. 513b3. Examination.

(a) The Director, or his or her designee, may examine a registered pharmacy benefit manager related to all of its lines of business, including government programs, under the Director's jurisdiction in accordance with Sections 132-132.7. If the Director or the examiners find that the pharmacy benefit manager has violated this Article or any other insurance-related or health benefits-related laws, rules, or regulations under the Director's jurisdiction because of the manner in which the pharmacy benefit manager has conducted business on behalf of a health insurer or plan sponsor, then, unless the health insurer or plan sponsor is included in the examination and has been afforded the same opportunity to request or participate in a hearing on the examination report, the examination report shall not allege a violation by the health insurer or plan sponsor and the Director's order based on the report shall not impose any requirements, prohibitions, or penalties on the health insurer or plan sponsor. Nothing in this Section shall prevent the Director from using any information obtained during the examination of an administrator to examine, investigate, or take other appropriate regulatory or legal action with respect to a health insurer or plan sponsor.

(b) The examination requirement for the pharmacy benefit manager to provide convenient and free access to all books and records under Sections 132 and 132.4 of this Code includes, at the Director's discretion, unredacted copies furnished electronically to the Director's market conduct surveillance personnel or examiners. Access must include information related to third-party entities affiliated or contracted with the pharmacy benefit manager, including, but not limited to, rebate aggregators and pharmacy services administrative organizations.

(c) The Department may examine any pharmacy benefit manager as often as the Department deems appropriate, but shall, at a minimum, conduct an examination of the 3 largest pharmacy benefit managers with the most covered individuals not less frequently than once every 5 years beginning in 2026, or following the conclusion of any market conduct exams already in progress for the 3 largest pharmacy benefit managers. In determining pharmacy benefit plan market share, the Department may consider, but is not limited to, the following:

(1) the number of covered individuals;

(2) the Illinois Market share;

(3) the number of drug-related claims;

(4) the total gross spending on drugs;

(5) the aggregate amounts of rebates, fees, and discounts remitted by the pharmacy benefit manager or rebate aggregator;

(6) the dispensing channel used;
(7) the previous violations; and
(8) the complaints received.
(Source: P.A. 103-897, eff. 1-1-25.)

Section 25. The Illinois Public Aid Code is amended by changing Sections 5-5.12b and 5-36 as follows:

(305 ILCS 5/5-5.12b)

Sec. 5-5.12b. Critical access care pharmacy program.

(a) As used in this Section:

"Critical access care pharmacy" means an Illinois-based brick and mortar retail pharmacy ~~that is~~ located in Illinois that is owned by a person or entity with an ownership or control interest in ~~a county with fewer than 50,000 residents and that owns~~ fewer than 10 pharmacies, is either located in a county with fewer than 50,000 residents or in a county with 50,000 or more residents and in an area within Illinois that is designated as a Medically Underserved Area by the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services and has attested and been approved by the Department for participation in the critical access care pharmacy program. A pharmacy that participates or contracts in the 340B program as a contract pharmacy shall not be considered a critical access pharmacy for the purpose of this Section.

"Critical access care pharmacy program payment" means the number of individual prescriptions a critical access care pharmacy fills during that quarter multiplied by the lesser of the individual payment amount or the dispensing reimbursement rate made by the Department under the medical assistance program as of April 1, 2018.

"Individual payment amount" means the dividend of 1/4 of the annual amount appropriated for the critical access care pharmacy program by the number of prescriptions filled by all critical access care pharmacies reimbursed by Medicaid managed care organizations that quarter.

"Ownership or control interest" has the meaning given to "person with an ownership or control interest" in 42 CFR 455.101.

(b) Subject to appropriations and federal approval, the Department shall establish a critical access care pharmacy program to ensure the sustainability of critical access pharmacies throughout the State of Illinois.

(c) The critical access care pharmacy program disbursed by the managed care plans shall not exceed $45,000,000 ~~$10,000,000~~ annually and individual payment amounts per prescription shall not exceed the brand name dispensing rate that the Department would have reimbursed to a critical access care pharmacy under the Medical Assistance Program as of July 1, 2024 ~~April 1, 2018~~.

(d) Annually, beginning January 1, 2026 ~~Quarterly~~, the Department shall determine the number of prescriptions filled by critical access care pharmacies reimbursed by Medicaid managed care organizations utilizing encounter data available to the Department. The Department shall determine the individual payment amount per prescription by dividing 1/4 of the annual amount appropriated for the critical access care pharmacy program by the number of prescriptions filled by all critical access care pharmacies reimbursed by Medicaid managed care organizations that quarter. If the individual payment amount per prescription as calculated using quarterly prescription amounts exceeds the reimbursement rate under the medical assistance program as of April 1, 2018, then the individual payment amount per prescription shall be the dispensing reimbursement rate under the medical assistance program as of April 1, 2018.

(e) Quarterly, the Department shall distribute to critical access care pharmacies a critical access care pharmacy program payment. The first payment shall be calculated utilizing the encounter data from the last quarter of State fiscal year 2018. This payment shall sunset on December 31, 2025.

(f) Effective January 1, 2026, the Department shall issue a quarterly directed critical access care pharmacy program payment to critical access care pharmacies for any prescription drug dispensed to a managed care client.

(g) ~~(f)~~ The Department may adopt rules necessary to implement this Section. The rules may include, but are not limited to, permitting an Illinois-based brick and mortar pharmacy that owns fewer than 10 pharmacies to receive critical access care pharmacy program payments in the same manner as a critical access care pharmacy, regardless of whether the pharmacy meets the other requirements of a critical access care pharmacy in subsection (a) ~~is located in a county with a population of less than 50,000~~.
(Source: P.A. 100-587, eff. 6-4-18.)

(305 ILCS 5/5-36)

Sec. 5-36. Pharmacy benefits.

(a)(1) The Department may enter into a contract with a third party on a fee-for-service reimbursement model for the purpose of administering pharmacy benefits as provided in this Section for members not enrolled in a Medicaid managed care organization; however, these services shall be approved by the Department. The Department shall ensure coordination of care between the third-party administrator and managed care organizations as a consideration in any contracts established in accordance with this Section. Any managed care techniques, principles, or administration of benefits utilized in accordance with this subsection shall comply with State law.

(2) The following shall apply to contracts between entities contracting relating to the Department's third-party administrators and pharmacies:

(A) the Department shall approve any contract between a third-party administrator and a pharmacy;

(B) the Department's third-party administrator shall not change the terms of a contract between a third-party administrator and a pharmacy without written approval by the Department; and

(C) the Department's third-party administrator shall not create, modify, implement, or indirectly establish any fee on a pharmacy, pharmacist, or a recipient of medical assistance without written approval by the Department.

(b) The provisions of this Section shall not apply to outpatient pharmacy services provided by a health care facility registered as a covered entity pursuant to 42 U.S.C. 256b or any pharmacy owned by or contracted with the covered entity. A Medicaid managed care organization shall, either directly or through a pharmacy benefit manager, administer and reimburse outpatient pharmacy claims submitted by a health care facility registered as a covered entity pursuant to 42 U.S.C. 256b, its owned pharmacies, and contracted pharmacies in accordance with the contractual agreements the Medicaid managed care organization or its pharmacy benefit manager has with such facilities and pharmacies and in accordance with subsection (h-5).

(b-5) Any pharmacy benefit manager that contracts with a Medicaid managed care organization to administer and reimburse pharmacy claims as provided in this Section must be registered with the Director of Insurance in accordance with Section 513b2 of the Illinois Insurance Code. A pharmacy benefit manager must comply with all provisions of Article XXXIIB of the Illinois Insurance Code to the extent that the provisions do not prevent the application of any provision of this Article or applicable federal law. Nothing in this Section shall be construed to limit the authority of the Illinois Department or the Inspector General to administer or enforce any provisions of this Section or any other Section in the Illinois Public Aid Code related to pharmacy benefit managers or Medicaid managed care entity.

(c) On at least an annual basis, the Director of the Department of Healthcare and Family Services shall submit a report beginning no later than one year after January 1, 2020 (the effective date of Public Act 101-452) that provides an update on any contract, contract issues, formulary, dispensing fees, and maximum allowable cost concerns regarding a third-party administrator and managed care. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report with the Speaker, the Minority Leader, and the Clerk of the House of Representatives and with the President, the Minority Leader, and the Secretary of the Senate. The Department shall take care that no proprietary information is included in the report required under this Section.

(d) (Blank). ~~A pharmacy benefit manager shall notify the Department in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy benefit manager's duty to a managed care organization to exercise its contractual duties. "Conflict of interest" shall be defined by rule by the Department.~~

(e) A pharmacy benefit manager shall, upon request, disclose to the Department the following information:

(1) whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a managed care organization's enrollees, and the aggregate amounts of consideration of economic benefits collected or received pursuant to that arrangement;

(2) the percentage of claims payments made by the pharmacy benefit manager to pharmacies owned, managed, or controlled by the pharmacy benefit manager or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, or jointly held companies;

(3) the aggregate amount of the fees or assessments imposed on, or collected from, pharmacy providers;

(4) the average annualized percentage of revenue collected by the pharmacy benefit manager as a result of each contract it has executed with a managed care organization contracted by the Department to provide medical assistance benefits which is not paid by the pharmacy benefit manager to pharmacy providers and pharmaceutical manufacturers or labelers or in order to perform administrative functions pursuant to its contracts with managed care organizations;

(5) the total number of prescriptions dispensed under each contract the pharmacy benefit manager has with a managed care organization (MCO) contracted by the Department to provide medical assistance benefits;

(6) the aggregate wholesale acquisition cost for drugs that were dispensed to enrollees in each MCO with which the pharmacy benefit manager has a contract by any pharmacy owned, managed, or controlled by the pharmacy benefit manager or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, or jointly-held companies;

(7) the aggregate amount of administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers for prescriptions dispensed to MCO enrollees;

(8) for each MCO with which the pharmacy benefit manager has a contract, the aggregate amount of payments received by the pharmacy benefit manager from the MCO;

(9) for each MCO with which the pharmacy benefit manager has a contract, the aggregate amount of reimbursements the pharmacy benefit manager paid to contracting pharmacies; and

(10) any other information considered necessary by the Department.

(f) The information disclosed under subsection (e) shall include all retail, mail order, specialty, and compounded prescription products. All information made available to the Department under subsection (e) is confidential and not subject to disclosure under the Freedom of Information Act. All information made available to the Department under subsection (e) shall not be reported or distributed in any way that compromises its competitive, proprietary, or financial value. The information shall only be used by the Department to assess the contract, agreement, or other arrangements made between a pharmacy benefit manager and a pharmacy provider, pharmaceutical manufacturer or labeler, managed care organization, or other entity, as applicable.

(g) A pharmacy benefit manager shall disclose directly in writing to a pharmacy provider or pharmacy services administrative organization contracting with the pharmacy benefit manager of any material change to a contract provision that affects the terms of the reimbursement, the process for verifying benefits and eligibility, dispute resolution, procedures for verifying drugs included on the formulary, and contract termination at least 30 days prior to the date of the change to the provision. The terms of this subsection shall be deemed met if the pharmacy benefit manager posts the information on a website, viewable by the public. A pharmacy service administration organization shall notify all contract pharmacies of any material change, as described in this subsection, within 2 days of notification. As used in this Section, "pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers. A pharmacy services administrative organization may provide administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies.

(h) A pharmacy benefit manager shall not include the following in a contract with a pharmacy provider:

(1) a provision prohibiting the provider from informing a patient of a less costly alternative to a prescribed medication; or

(2) a provision that prohibits the provider from dispensing a particular amount of a prescribed medication, if the pharmacy benefit manager allows that amount to be dispensed through a pharmacy owned or controlled by the pharmacy benefit manager, unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(h-5) Unless required by law, a Medicaid managed care organization or pharmacy benefit manager administering or managing benefits on behalf of a Medicaid managed care organization shall not refuse to contract with a 340B entity or 340B pharmacy for refusing to accept less favorable payment terms or reimbursement methodologies when compared to similarly situated non-340B entities and shall not include in a contract with a 340B entity or 340B pharmacy a provision that:

(1) imposes any fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(2) imposes any fee, chargeback, or rate adjustment that exceeds the fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(3) prevents or interferes with an individual's choice to receive a prescription drug from a 340B entity or 340B pharmacy through any legally permissible means;

(4) excludes a 340B entity or 340B pharmacy from a pharmacy network on the basis of whether the 340B entity or 340B pharmacy participates in the 340B drug discount program;

(5) prevents a 340B entity or 340B pharmacy from using a drug purchased under the 340B drug discount program so long as the drug recipient is a patient of the 340B entity; nothing in this Section exempts a 340B pharmacy from following the Department's preferred drug list or from any prior approval requirements of the Department or the Medicaid managed care organization that are imposed on the drug for all pharmacies; or

(6) any other provision that discriminates against a 340B entity or 340B pharmacy by treating a 340B entity or 340B pharmacy differently than non-340B entities or non-340B pharmacies for any reason relating to the entity's participation in the 340B drug discount program.

A provision that violates this subsection in any contract between a Medicaid managed care organization or its pharmacy benefit manager and a 340B entity entered into, amended, or renewed after July 1, 2022 shall be void and unenforceable.

In this subsection (h-5):

"340B entity" means a covered entity as defined in 42 U.S.C. 256b(a)(4) authorized to participate in the 340B drug discount program.

"340B pharmacy" means any pharmacy used to dispense 340B drugs for a covered entity, whether entity-owned or external.

(i) Nothing in this Section shall be construed to prohibit a pharmacy benefit manager from requiring the same reimbursement and terms and conditions for a pharmacy provider as for a pharmacy owned, controlled, or otherwise associated with the pharmacy benefit manager.

(j) A pharmacy benefit manager shall establish and implement a process for the resolution of disputes arising out of this Section, which shall be approved by the Department.

(k) The Department shall adopt rules establishing reasonable dispensing fees for fee-for-service payments in accordance with guidance or guidelines from the federal Centers for Medicare and Medicaid Services.

(Source: P.A. 102-558, eff. 8-20-21; 102-778, eff. 7-1-22; 103-593, eff. 6-7-24.)

Section 30. The Juvenile Court Act of 1987 is amended by changing Section 5-515 as follows:

(705 ILCS 405/5-515)

Sec. 5-515. Medical, ~~and~~ dental, and pharmaceutical treatment and care.

(a) At all times during temporary custody, detention or shelter care, the court may authorize a physician, a hospital or any other appropriate health care provider to provide medical, dental or surgical procedures or pharmaceuticals if those procedures or pharmaceuticals are necessary to safeguard the minor's life or health. If the minor is covered under an existing medical or dental plan, the county shall be reimbursed for the expenses incurred for such services as if the minor were not held in temporary custody, detention, or shelter care.

(b) If a provider of temporary custody, detention, or shelter care has a contract with a pharmacy benefit manager or a contract with an insurance company, health maintenance organization, limited health service organization, administrative services organization, or any other managed care organization or health insurance issuer where a pharmacy benefit manager administers the provider's coverage of, payment for, or formulary design for drugs necessary to safeguard the minor's life or health, the contract with the pharmacy benefit manager and the pharmacy benefit manager's activities shall be subject to Article XXXIIB of the Illinois Insurance Code and the authority of the Director of Insurance to enforce those provisions. The provider shall have all the rights of a plan sponsor under those provisions.

(Source: P.A. 90-590, eff. 1-1-99.)

Section 35. The Unified Code of Corrections is amended by changing Section 3-2-2 as follows:

(730 ILCS 5/3-2-2) (from Ch. 38, par. 1003-2-2)

Sec. 3-2-2. Powers and duties of the Department.

(1) In addition to the powers, duties, and responsibilities which are otherwise provided by law, the Department shall have the following powers:

(a) To accept persons committed to it by the courts of this State for care, custody, treatment, and rehabilitation, and to accept federal prisoners and noncitizens over whom the Office of the Federal Detention Trustee is authorized to exercise the federal detention function for limited purposes and periods of time.

(b) To develop and maintain reception and evaluation units for purposes of analyzing the custody and rehabilitation needs of persons committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies. In consultation with the Department of Alcoholism and Substance Abuse (now the Department of Human Services), the Department of Corrections shall develop a master plan for the screening and evaluation of persons committed to its custody who have alcohol or drug abuse problems, and for making appropriate treatment available to such persons; the Department shall report to the General Assembly on such plan not later than April 1, 1987. The maintenance and implementation of such plan shall be contingent upon the availability of funds.

(b-1) To create and implement, on January 1, 2002, a pilot program to establish the effectiveness of pupillometer technology (the measurement of the pupil's reaction to light) as an alternative to a urine test for purposes of screening and evaluating persons committed to its custody who have alcohol or drug problems. The pilot program shall require the pupillometer technology to be used in at least one Department of Corrections facility. The Director may expand the pilot program to include an additional facility or facilities as he or she deems appropriate. A minimum of 4,000 tests shall be included in the pilot program. The Department must report to the General Assembly on the effectiveness of the program by January 1, 2003.

(b-5) To develop, in consultation with the Illinois State Police, a program for tracking and evaluating each inmate from commitment through release for recording his or her gang affiliations, activities, or ranks.

(c) To maintain and administer all State correctional institutions and facilities under its control and to establish new ones as needed. Pursuant to its power to establish new institutions and facilities, the Department may, with the written approval of the Governor, authorize the Department of Central Management Services to enter into an agreement of the type described in subsection (d) of Section 405-300 of the Department of Central Management Services Law. The Department shall designate those institutions which shall constitute the State Penitentiary System. The Department of Juvenile Justice shall maintain and administer all State youth centers pursuant to subsection (d) of Section 3-2.5-20.

Pursuant to its power to establish new institutions and facilities, the Department may authorize the Department of Central Management Services to accept bids from counties and municipalities for the construction, remodeling, or conversion of a structure to be leased to the Department of Corrections for the purposes of its serving as a correctional institution or facility. Such construction, remodeling, or conversion may be financed with revenue bonds issued pursuant to the Industrial Building Revenue Bond Act by the municipality or county. The lease specified in a bid shall be for a term of not less than the time needed to retire any revenue bonds used to finance the project, but not to exceed 40 years. The lease may grant to the State the option to purchase the structure outright.

Upon receipt of the bids, the Department may certify one or more of the bids and shall submit any such bids to the General Assembly for approval. Upon approval of a bid by a constitutional majority of both houses of the General Assembly, pursuant to joint resolution, the Department of Central Management Services may enter into an agreement with the county or municipality pursuant to such bid.

(c-5) To build and maintain regional juvenile detention centers and to charge a per diem to the counties as established by the Department to defray the costs of housing each minor in a center. In this subsection (c-5), "juvenile detention center" means a facility to house minors during pendency of trial who have been transferred from proceedings under the Juvenile Court Act of 1987 to prosecutions under the criminal laws of this State in accordance with Section 5-805 of the Juvenile Court Act of 1987, whether the transfer was by operation of law or permissive under that Section. The Department shall designate the counties to be served by each regional juvenile detention center.

(d) To develop and maintain programs of control, rehabilitation, and employment of committed persons within its institutions.

(d-5) To provide a pre-release job preparation program for inmates at Illinois adult correctional centers.

(d-10) To provide educational and visitation opportunities to committed persons within its institutions through temporary access to content-controlled tablets that may be provided as a privilege to committed persons to induce or reward compliance.

(e) To establish a system of supervision and guidance of committed persons in the community.

(f) To establish in cooperation with the Department of Transportation to supply a sufficient number of prisoners for use by the Department of Transportation to clean up the trash and garbage along State, county, township, or municipal highways as designated by the Department of Transportation. The Department of Corrections, at the request of the Department of Transportation, shall furnish such prisoners at least annually for a period to be agreed upon between the Director of Corrections and the Secretary of Transportation. The prisoners used on this program shall be selected by the Director of Corrections on whatever basis he deems proper in consideration of their term, behavior and earned eligibility to participate in such program - where they will be outside of the prison facility but still in the custody of the Department of Corrections. Prisoners convicted of first degree murder, or a Class X felony, or armed violence, or aggravated kidnapping, or criminal sexual assault, aggravated criminal sexual abuse or a subsequent conviction for criminal sexual abuse, or forcible detention, or arson, or a prisoner adjudged a Habitual Criminal shall not be eligible for selection to participate in such program. The prisoners shall remain as prisoners in the custody of the Department of Corrections and such Department shall furnish whatever security is necessary. The Department of Transportation shall furnish trucks and equipment for the highway cleanup program and personnel to supervise and direct the program. Neither the Department of Corrections nor the Department of Transportation shall replace any regular employee with a prisoner.

(g) To maintain records of persons committed to it and to establish programs of research, statistics, and planning.

(h) To investigate the grievances of any person committed to the Department and to inquire into any alleged misconduct by employees or committed persons; and for these purposes it may issue subpoenas and compel the attendance of witnesses and the production of writings and papers, and may examine under oath any witnesses who may appear before it; to also investigate alleged violations of a parolee's or releasee's conditions of parole or release; and for this purpose it may issue subpoenas and compel the attendance of witnesses and the production of documents only if there is reason to believe that such procedures would provide evidence that such violations have occurred.

If any person fails to obey a subpoena issued under this subsection, the Director may apply to any circuit court to secure compliance with the subpoena. The failure to comply with the order of the court issued in response thereto shall be punishable as contempt of court.

(i) To appoint and remove the chief administrative officers, and administer programs of training and development of personnel of the Department. Personnel assigned by the Department to be responsible for the custody and control of committed persons or to investigate the alleged misconduct of committed persons or employees or alleged violations of a parolee's or releasee's conditions of parole shall be conservators of the peace for those purposes, and shall have the full power of peace officers outside of the facilities of the Department in the protection, arrest, retaking, and reconfining of committed persons or where the exercise of such power is necessary to the investigation of such misconduct or violations. This subsection shall not apply to persons committed to the Department of Juvenile Justice under the Juvenile Court Act of 1987 on aftercare release.

(j) To cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services in this State.

(k) To administer all moneys and properties of the Department.

(l) To report annually to the Governor on the committed persons, institutions, and programs of the Department.

(l-5) (Blank).

(m) To make all rules and regulations and exercise all powers and duties vested by law in the Department.

(n) To establish rules and regulations for administering a system of sentence credits, established in accordance with Section 3-6-3, subject to review by the Prisoner Review Board.

(o) To administer the distribution of funds from the State Treasury to reimburse counties where State penal institutions are located for the payment of assistant state's attorneys' salaries under Section 4-2001 of the Counties Code.

(p) To exchange information with the Department of Human Services and the Department of Healthcare and Family Services for the purpose of verifying living arrangements and for other purposes directly connected with the administration of this Code and the Illinois Public Aid Code.

(q) To establish a diversion program.

The program shall provide a structured environment for selected technical parole or mandatory supervised release violators and committed persons who have violated the rules governing their conduct while in work release. This program shall not apply to those persons who have committed a new offense while serving on parole or mandatory supervised release or while committed to work release.

Elements of the program shall include, but shall not be limited to, the following:

(1) The staff of a diversion facility shall provide supervision in accordance with required objectives set by the facility.

(2) Participants shall be required to maintain employment.

(3) Each participant shall pay for room and board at the facility on a sliding-scale basis according to the participant's income.

(4) Each participant shall:

(A) provide restitution to victims in accordance with any court order;

(B) provide financial support to his dependents; and

(C) make appropriate payments toward any other court-ordered obligations.

(5) Each participant shall complete community service in addition to employment.

(6) Participants shall take part in such counseling, educational, and other programs as the Department may deem appropriate.

(7) Participants shall submit to drug and alcohol screening.

(8) The Department shall promulgate rules governing the administration of the program.

(r) To enter into intergovernmental cooperation agreements under which persons in the custody of the Department may participate in a county impact incarceration program established under Section 3-6038 or 3-15003.5 of the Counties Code.

(r-5) (Blank).

(r-10) To systematically and routinely identify with respect to each streetgang active within the correctional system: (1) each active gang; (2) every existing inter-gang affiliation or alliance; and (3) the current leaders in each gang. The Department shall promptly segregate leaders from inmates who belong to their gangs and allied gangs. "Segregate" means no physical contact and, to the extent possible under the conditions and space available at the correctional facility, prohibition of visual and sound communication. For the purposes of this paragraph (r-10), "leaders" means persons who:

(i) are members of a criminal streetgang;

(ii) with respect to other individuals within the streetgang, occupy a position of organizer, supervisor, or other position of management or leadership; and

(iii) are actively and personally engaged in directing, ordering, authorizing, or requesting commission of criminal acts by others, which are punishable as a felony, in furtherance of streetgang related activity both within and outside of the Department of Corrections.

"Streetgang", "gang", and "streetgang related" have the meanings ascribed to them in Section 10 of the Illinois Streetgang Terrorism Omnibus Prevention Act.

(s) To operate a super-maximum security institution, in order to manage and supervise inmates who are disruptive or dangerous and provide for the safety and security of the staff and the other inmates.

(t) To monitor any unprivileged conversation or any unprivileged communication, whether in person or by mail, telephone, or other means, between an inmate who, before commitment to the Department, was a member of an organized gang and any other person without the need to show cause or satisfy any other requirement of law before beginning the monitoring, except as constitutionally required. The monitoring may be by video, voice, or other method of recording or by any other means. As used in this subdivision (1)(t), "organized gang" has the meaning ascribed to it in Section 10 of the Illinois Streetgang Terrorism Omnibus Prevention Act.

As used in this subdivision (1)(t), "unprivileged conversation" or "unprivileged communication" means a conversation or communication that is not protected by any privilege recognized by law or by decision, rule, or order of the Illinois Supreme Court.

(u) To establish a Women's and Children's Pre-release Community Supervision Program for the purpose of providing housing and services to eligible female inmates, as determined by the Department, and their newborn and young children.

(u-5) To issue an order, whenever a person committed to the Department absconds or absents himself or herself, without authority to do so, from any facility or program to which he or she is assigned. The order shall be certified by the Director, the Supervisor of the Apprehension Unit, or any person duly designated by the Director, with the seal of the Department affixed. The order shall be directed to all sheriffs, coroners, and police officers, or to any particular person named in the order. Any order issued pursuant to this subdivision (1)(u-5) shall be sufficient warrant for the officer or person named in the order to arrest and deliver the committed person to the proper correctional officials and shall be executed the same as criminal process.

(u-6) To appoint a point of contact person who shall receive suggestions, complaints, or other requests to the Department from visitors to Department institutions or facilities and from other members of the public.

(v) To do all other acts necessary to carry out the provisions of this Chapter.

(2) The Department of Corrections shall by January 1, 1998, consider building and operating a correctional facility within 100 miles of a county of over 2,000,000 inhabitants, especially a facility designed to house juvenile participants in the impact incarceration program.

(3) When the Department lets bids for contracts for medical services to be provided to persons committed to Department facilities by a health maintenance organization, medical service corporation, or other health care provider, the bid may only be let to a health care provider that has obtained an irrevocable letter of credit or performance bond issued by a company whose bonds have an investment grade or higher rating by a bond rating organization.

(3.5) If the Department has a contract with a pharmacy benefit manager or a contract with an insurance company, health maintenance organization, limited health service organization, administrative services organization, or any other managed care entity or health insurance issuer where a pharmacy benefit manager administers the provider's coverage of, payment for, or formulary design for drugs necessary to safeguard the minor's life or health, the contract with the pharmacy benefit manager and the pharmacy benefit manager's activities shall be subject to Article XXXIIB of the Illinois Insurance Code and the authority of the Director of Insurance to enforce those provisions. The provider shall have all the rights of a plan sponsor under those provisions.

(4) When the Department lets bids for contracts for food or commissary services to be provided to Department facilities, the bid may only be let to a food or commissary services provider that has obtained an irrevocable letter of credit or performance bond issued by a company whose bonds have an investment grade or higher rating by a bond rating organization.

(5) On and after the date 6 months after August 16, 2013 (the effective date of Public Act 98-488), as provided in the Executive Order 1 (2012) Implementation Act, all of the powers, duties, rights, and responsibilities related to State healthcare purchasing under this Code that were transferred from the Department of Corrections to the Department of Healthcare and Family Services by Executive Order 3 (2005) are transferred back to the Department of Corrections; however, powers, duties, rights, and responsibilities related to State healthcare purchasing under this Code that were exercised by the Department of Corrections before the effective date of Executive Order 3 (2005) but that pertain to individuals resident in facilities operated by the Department of Juvenile Justice are transferred to the Department of Juvenile Justice.

(6) The Department of Corrections shall provide lactation or nursing mothers rooms for personnel of the Department. The rooms shall be provided in each facility of the Department that employs nursing mothers. Each individual lactation room must:

(i) contain doors that lock;

(ii) have an "Occupied" sign for each door;

(iii) contain electrical outlets for plugging in breast pumps;

(iv) have sufficient lighting and ventilation;

(v) contain comfortable chairs;

(vi) contain a countertop or table for all necessary supplies for lactation;

(vii) contain a wastebasket and chemical cleaners to wash one's hands and to clean the surfaces of the countertop or table;

(viii) have a functional sink;

(ix) have a minimum of one refrigerator for storage of the breast milk; and

(x) receive routine daily maintenance.

(Source: P.A. 102-350, eff. 8-13-21; 102-535, eff. 1-1-22; 102-538, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1030, eff. 5-27-22; 103-834, eff. 1-1-25.)

Section 40. The County Jail Act is amended by changing Section 17 as follows:

(730 ILCS 125/17) (from Ch. 75, par. 117)

Sec. 17. Bedding, clothing, fuel, and medical aid; reimbursement for medical expenses. The Warden of the jail shall furnish necessary bedding, clothing, fuel, and medical services for all committed persons under his charge, and keep an accurate account of the same. When services that result in qualified medical expenses are required by any person held in custody, the county, private hospital, physician or any public agency which provides such services shall be entitled to obtain reimbursement from the county for the cost of such services. The county board of a county may adopt an ordinance or resolution providing for reimbursement for the cost of those services at the Department of Healthcare and Family Services' rates for medical assistance. To the extent that such person is reasonably able to pay for such care, including reimbursement from any insurance program or from other medical benefit programs available to such person, he or she shall reimburse the county or arresting authority. If such person has already been determined eligible for medical assistance under the Illinois Public Aid Code at the time the person is detained, the cost of such services, to the extent such cost exceeds $500, shall be reimbursed by the Department of Healthcare and Family Services under that Code. A reimbursement under any public or private program authorized by this Section shall be paid to the county or arresting authority to the same extent as would have been obtained had the services been rendered in a non-custodial environment.

The sheriff or his or her designee may cause an application for medical assistance under the Illinois Public Aid Code to be completed for an arrestee who is a hospital inpatient. If such arrestee is determined eligible, he or she shall receive medical assistance under the Code for hospital inpatient services only. An arresting authority shall be responsible for any qualified medical expenses relating to the arrestee until such time as the arrestee is placed in the custody of the sheriff. However, the arresting authority shall not be so responsible if the arrest was made pursuant to a request by the sheriff. When medical expenses are required by any person held in custody, the county shall be entitled to obtain reimbursement from the County Jail Medical Costs Fund to the extent moneys are available from the Fund. To the extent that the person is reasonably able to pay for that care, including reimbursement from any insurance program or from other medical benefit programs available to the person, he or she shall reimburse the county.

For the purposes of this Section, "arresting authority" means a unit of local government, other than a county, which employs peace officers and whose peace officers have made the arrest of a person. For the purposes of this Section, "qualified medical expenses" include medical and hospital services but do not include (i) expenses incurred for medical care or treatment provided to a person on account of a self-inflicted injury incurred prior to or in the course of an arrest, (ii) expenses incurred for medical care or treatment provided to a person on account of a health condition of that person which existed prior to the time of his or her arrest, or (iii) expenses for hospital inpatient services for arrestees enrolled for medical assistance under the Illinois Public Aid Code.

If a jail or a unit of local government operating the jail has a contract with a pharmacy benefit manager or a contract with an insurance company, health maintenance organization, limited health service organization, administrative services organization, or any other managed care organization or health insurance issuer where a pharmacy benefit manager administers coverage of, payment for, or formulary design for drugs necessary to safeguard the life or health of any person in custody, that contract and the pharmacy benefit manager's activities shall be subject to Article XXXIIB of the Illinois Insurance Code and the authority of the Director of Insurance to enforce those provisions. The jail or unit of local government shall have all the rights of a plan sponsor under those provisions.

(Source: P.A. 103-745, eff. 1-1-25.)

Section 99. Effective date. This Act takes effect on January 1, 2026, except that this Section, Section 10, and the changes to Sections 513b2 and 513b3 of the Illinois Insurance Code take effect upon

becoming law.".

The motion prevailed.
And the amendment was adopted and ordered printed.
Floor Amendment No. 3 was withdrawn by the sponsor.
Senator Koehler offered the following amendment and moved its adoption:

AMENDMENT NO. 4 TO HOUSE BILL 1697

AMENDMENT NO. 4 . Amend House Bill 1697, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 2, on page 22, line 4, after "single-employer" by inserting "or multiemployer"; and

on page 30, line 12, after "Fund", by inserting "for grants to pharmacies under Section 605-60 of the Department of Commerce and Economic Opportunity Law"; and

on page 33, by replacing lines 12 through 15 with the following:
"critical access care pharmacy program."; and

on page 34, immediately below line 14, by inserting the following:
"(c-5) 340B pharmacies that are participants in the critical access care pharmacy program shall only be reimbursed for the actual acquisition costs of the 340B covered drugs dispensed to participants in the State's medical assistance program as defined in the Illinois Public Aid Code.".

The motion prevailed.
And the amendment was adopted and ordered printed.

Pursuant to Senate Rule 3-8 (d-10), the Senate Parliamentarian has determined **Floor Amendment No. 5 to House Bill 1697** is technical in nature and is approved for consideration by the Senate without referral to the Committee on Assignments.
Senator Koehler offered the following amendment and moved its adoption:

AMENDMENT NO. 5 TO HOUSE BILL 1697

AMENDMENT NO. 5 . Amend House Bill 1697, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 2, on page 30, lines 12 through 14, by deleting "Moneys deposited into the Prescription Drug Affordability Fund shall be used to pay the expenses of the Department.".

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.

At the hour of 6:38 o'clock p.m., the Honorable Don Harmon, President of the Senate, presiding.

At the hour of 6:44 o'clock p.m., Senator Aquino, presiding.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Koehler, **House Bill No. 1697** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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; NAY 1.

The following voted in the affirmative:

Anderson	Faraci	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Tracy
Arellano, L.	Fine	Lewis	Turner, D.
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	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	Sims	

The following voted in the negative:

Syverson

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 in the Senate Amendments adopted thereto.

POSTING NOTICES WAIVED

Senator Villa moved to waive the six-day posting requirement on **House Bill No. 2682** so that the measure may be heard in the Committee on Health and Human Services that is scheduled to meet May 30, 2025.

The motion prevailed.

Senator Joyce moved to waive the six-day posting requirement on **House Bill No. 3140** so that the measure may be heard in the Committee on State Government that is scheduled to meet May 29, 2025.

The motion prevailed.

Senator Cunningham moved to waive the six-day posting requirement on **House Bills numbered 850, 3247 and 3363** so that the measures may be heard in the Committee on Executive that is scheduled to meet May 29, 2025.

The motion prevailed.

READING BILL FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Villivalam, **House Bill No. 3177** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, 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 57; NAYS None.

The following voted in the affirmative:

Anderson	Faraci	Joyce	Stadelman
Aquino	Feigenholtz	Koehler	Syverson
Arellano, L.	Fine	Lewis	Tracy
Balkema	Fowler	Martwick	Turner, D.
Belt	Glowiak Hilton	McClure	Turner, S.
Bryant	Guzmán	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Chesney	Harriss, E.	Plummer	Villivalam
Collins	Hastings	Porfirio	Walker
Cunningham	Hills	Preston	Wilcox
Curran	Holmes	Rezin	Mr. President
DeWitte	Hunter	Rose	
Edly-Allen	Johnson	Simmons	
Ellman	Jones, E.	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 in the Senate Amendment adopted thereto.

At the hour of 7:18 o'clock p.m., Senator Koehler, presiding.

MESSAGES FROM THE HOUSE

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 26

A bill for AN ACT concerning civil law.

Together with the following amendments which are attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 26

House Amendment No. 2 to SENATE BILL NO. 26

Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 26

AMENDMENT NO. 1 . Amend Senate Bill 26 by replacing everything after the enacting clause with the following:

"Section 5. The Code of Civil Procedure is amended by changing Section 1-101 as follows:

(735 ILCS 5/1-101) (from Ch. 110, par. 1-101)

Sec. 1-101. Short titles.

(a) This Act shall be known and ~~and~~ may be cited as the "Code of Civil Procedure".

(b) Article II shall be known as the "Civil Practice Law" and may be referred to by that designation.

(c) Article III shall be known as the "Administrative Review Law" and may be referred to by that designation.

(Source: P.A. 82-280.)".

AMENDMENT NO. 2 TO SENATE BILL 26

AMENDMENT NO. 2 . Amend Senate Bill 26, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Code of Civil Procedure is amended by changing Section 2-209 as follows:

(735 ILCS 5/2-209) (from Ch. 110, par. 2-209)

Sec. 2-209. Act submitting to jurisdiction - Process.

(a) Any person, whether or not a citizen or resident of this State, who in person or through an agent does any of the acts hereinafter enumerated, thereby submits such person, and, if an individual, his or her personal representative, to the jurisdiction of the courts of this State as to any cause of action arising from the doing of any of such acts:

(1) The transaction of any business within this State;

(2) The commission of a tortious act within this State;

(3) The ownership, use, or possession of any real estate situated in this State;

(4) Contracting to insure any person, property or risk located within this State at the time of contracting;

(5) With respect to actions of dissolution of marriage, declaration of invalidity of marriage and legal separation, the maintenance in this State of a matrimonial domicile at the time this cause of action arose or the commission in this State of any act giving rise to the cause of action;

(6) With respect to actions brought under the Illinois Parentage Act of 1984, as now or hereafter amended, or under the Illinois Parentage Act of 2015 on and after the effective date of that Act, the performance of an act of sexual intercourse within this State during the possible period of conception;

(7) The making or performance of any contract or promise substantially connected with this State;

(8) The performance of sexual intercourse within this State which is claimed to have resulted in the conception of a child who resides in this State;

(9) The failure to support a child, spouse or former spouse who has continued to reside in this State since the person either formerly resided with them in this State or directed them to reside in this State;

(10) The acquisition of ownership, possession or control of any asset or thing of value present within this State when ownership, possession or control was acquired;

(11) The breach of any fiduciary duty within this State;

(12) The performance of duties as a director or officer of a corporation organized under the laws of this State or having its principal place of business within this State;

(13) The ownership of an interest in any trust administered within this State; or

(14) The exercise of powers granted under the authority of this State as a fiduciary.

(b) A court may exercise general jurisdiction in any action arising within or without this State against any person who:

(1) Is a natural person present within this State when served;

(2) Is a natural person domiciled or resident within this State when the cause of action arose, the action was commenced, or process was served;

(3) Is a corporation organized under the laws of this State or having its principal place of business in this State; ~~or~~

(4) Is a natural person or corporation doing business within this State; or

(5) Is a foreign business corporation that has consented to general jurisdiction in this State in accordance with subsection (b) of Section 13.20 or subsection (d) of Section 13.70 of the Business Corporation Act of 1983, but only if (i) the action alleges injury or illness resulting from exposure to a substance defined as toxic under the Uniform Hazardous Substances Act of Illinois, whether the cause of action arises within or without this State, and (ii) jurisdiction is proper as to one or more named co-defendants under subsection (a) of this Section.

(b-5) Foreign defamation judgment. The courts of this State shall have personal jurisdiction over any person who obtains a judgment in a defamation proceeding outside the United States against any person who is a resident of Illinois or, if not a natural person, has its principal place of business in Illinois, for the purposes of rendering declaratory relief with respect to that resident's liability for the judgment, or for the purpose of determining whether said judgment should be deemed non-recognizable pursuant to this Code, to the fullest extent permitted by the United States Constitution, provided:

(1) the publication at issue was published in Illinois, and

(2) that resident (i) has assets in Illinois which might be used to satisfy the foreign defamation judgment, or (ii) may have to take actions in Illinois to comply with the foreign defamation judgment.

The provisions of this subsection (b-5) shall apply to persons who obtained judgments in defamation proceedings outside the United States prior to, on, or after the effective date of this amendatory Act of the 95th General Assembly.

(c) A court may also exercise jurisdiction on any other basis now or hereafter permitted by the Illinois Constitution and the Constitution of the United States.

(d) Service of process upon any person who is subject to the jurisdiction of the courts of this State, as provided in this Section, may be made by personally serving the summons upon the defendant outside this State, as provided in this Act, with the same force and effect as though summons had been personally served within this State.

(e) Service of process upon any person who resides or whose business address is outside the United States and who is subject to the jurisdiction of the courts of this State, as provided in this Section, in any action based upon product liability may be made by serving a copy of the summons with a copy of the complaint attached upon the Secretary of State. The summons shall be accompanied by a $5 fee payable to the Secretary of State. The plaintiff shall forthwith mail a copy of the summons, upon which the date of service upon the Secretary is clearly shown, together with a copy of the complaint to the defendant at his or her last known place of residence or business address. Plaintiff shall file with the circuit clerk an affidavit of the plaintiff or his or her attorney stating the last known place of residence or the last known business address of the defendant and a certificate of mailing a copy of the summons and complaint to the defendant at such address as required by this subsection (e). The certificate of mailing shall be prima facie evidence that the plaintiff or his or her attorney mailed a copy of the summons and complaint to the defendant as required. Service of the summons shall be deemed to have been made upon the defendant on the date it is served upon the Secretary and shall have the same force and effect as though summons had been personally served upon the defendant within this State.

(f) Only causes of action arising from acts enumerated herein may be asserted against a defendant in an action in which jurisdiction over him or her is based upon subsection (a).

(g) Nothing herein contained limits or affects the right to serve any process in any other manner now or hereafter provided by law.

(Source: P.A. 99-85, eff. 1-1-16.)

Section 10. The Business Corporation Act of 1983 is amended by changing Sections 13.20 and 13.70 as follows:

(805 ILCS 5/13.20) (from Ch. 32, par. 13.20)

Sec. 13.20. Effect of authority.

(a) Upon the filing of the application for authority by the Secretary of State, the corporation shall have the right to transact business in this State for those purposes set forth in its application, subject, however, to the right of this State to revoke such right to transact business in this State as provided in this Act.

(b) A corporation that obtains or continues to maintain the right to transact business in this State consents to the exercise of general jurisdiction by the courts of this State in accordance with paragraph (5) of subsection (b) of Section 2-209 of the Code of Civil Procedure.

A corporation consents to general jurisdiction upon registering to do business in this State at any time following the effective date of this amendatory Act of the 104th General Assembly.

A corporation that has previously registered to do business in this State consents to general jurisdiction upon the next date after the effective date of this amendatory Act of the 104th General Assembly on which the filing of its annual report in accordance of Section 14.05 is due, regardless of whether or not it then files its annual report.

Consent to such general jurisdiction terminates upon, and only upon, formal withdrawal from this State.

(Source: P.A. 92-33, eff. 7-1-01.)

(805 ILCS 5/13.70) (from Ch. 32, par. 13.70)

Sec. 13.70. Transacting business without authority.

(a) No foreign corporation transacting business in this State without authority to do so is permitted to maintain a civil action in any court of this State, until the corporation obtains that authority. Nor shall a civil action be maintained in any court of this State by any successor or assignee of the corporation on any right,

claim or demand arising out of the transaction of business by the corporation in this State, until authority to transact business in this State is obtained by the corporation or by a corporation that has acquired all or substantially all of its assets.

(b) The failure of a foreign corporation to obtain authority to transact business in this State does not impair the validity of any contract or act of the corporation, and does not prevent the corporation from defending any action in any court of this State.

(c) A foreign corporation that transacts business in this State without authority is liable to this State, for the years or parts thereof during which it transacted business in this State without authority, in an amount equal to all fees, franchise taxes, penalties and other charges that would have been imposed by this Act upon the corporation had it duly applied for and received authority to transact business in this State as required by this Act, but failed to pay the franchise taxes that would have been computed thereon, and thereafter filed all reports required by this Act; and, if a corporation fails to file an application for authority within 60 days after it commences business in this State, in addition thereto it is liable for a penalty of either 10% of the filing fee, license fee and franchise taxes or $200 plus $5.00 for each month or fraction thereof in which it has continued to transact business in this State without authority therefor, whichever penalty is greater. The Attorney General shall bring proceedings to recover all amounts due this State under this Section.

(c-5) A foreign corporation that transacts business in this State without authority is deemed to have consented to general jurisdiction in accordance with subsection (b) of Section 13.20 to the same extent as if it were registered to do business in this State. Consent to such general jurisdiction commences upon committing an act constituting the transaction of business in this State without authority at any time after the effective date of this amendatory Act of the 104th General Assembly and remains effective for 180 days following the committing of each and every such act.

(d) The Attorney General shall bring an action to restrain a foreign corporation from transacting business in this State, if the authority of the foreign corporation to transact business has been revoked under subsection (m) of Section 13.50 of this Act.

(Source: P.A. 95-515, eff. 8-28-07.)

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

Under the rules, the foregoing **Senate Bill No. 26**, with House Amendments numbered 1 and 2, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 637

A bill for AN ACT concerning local government.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 637

Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 637

AMENDMENT NO. 1 . 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 15 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.".

Under the rules, the foregoing **Senate Bill No. 637**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2201

A bill for AN ACT concerning criminal law.

Together with the following amendments which are attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 2201

House Amendment No. 3 to SENATE BILL NO. 2201

House Amendment No. 4 to SENATE BILL NO. 2201

Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 2201

AMENDMENT NO. 1 . Amend Senate Bill 2201 by replacing everything after the enacting clause with the following:

"Section 5. The Unified Code of Corrections is amended by adding Section 3-2-15 as follows:

(730 ILCS 5/3-2-15 new)

Sec. 3-2-15. Department of Corrections; report of contraband. The Department of Corrections shall annually collect and publish on its website the following data:

(1) contraband:

(A) identified by facility;

(B) identified by the place in the facility where the contraband was found, such as cell, visiting room, and correctional employee dining facility;

(C) method of entrance to the facility, such as correctional employee entrance, visitor entrance, vendor entrance, delivery person entrance, mail delivery, attorney visit, and other entrances to the facility;

(D) searches of persons and vehicles entering the facility;

(E) type of contraband:

(i) drugs: specified by type or kind:

(I) item tested;

(II) test used;

(III) test results;

(ii) phones;

(iii) weapons;

(iv) other contraband; and

(F) disciplinary tickets due to possession of or attempt to procure contraband:

(i) by facility;

(ii) by person or committed person;

(iii) findings from disciplinary proceedings;

(iv) punishment and consequences imposed;

(2) substance use disorder treatment or educational programming data by facility:

(A) available treatment programs indicating level of treatment: substance used education or intensive services;

(B) number of participants; and

(C) number of committed persons on waitlist;

(3) use of naloxone:

(A) number of persons, either a correctional employee or committed person, who received naloxone, not the person administering naloxone;

(4) emergency medical response and hospitalizations:

(A) by facility;

(B) for what reason; and

(C) outcomes (transported by ambulance, seen and discharged, admitted, deceased); and

(5) overdoses:

(A) identified by outside medical professionals or the coroner;

(B) tracked by medical diagnosis or cause of death;

(C) by facility; and

(D) by person (correctional employee and committed person).

The data described in paragraph (1) shall be collected beginning July 1, 2026 and shall be published annually on or before August 1 of each year. All other data described in paragraphs (2) through (5) shall be collected beginning July 1, 2027 and shall be published annually on or before August 1 of each year.

Section 99. Effective date. This Act takes effect July 1, 2026.".

AMENDMENT NO. 3 TO SENATE BILL 2201

AMENDMENT NO. 3 . Amend Senate Bill 2201, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Unified Code of Corrections is amended by adding Section 3-2-15 as follows:

(730 ILCS 5/3-2-15 new)

Sec. 3-2-15. Department of Corrections; report of contraband. The Department of Corrections shall annually collect and publish on its website the following data:

(1) contraband-related data:

(A) identified by facility;

(B) identified by the place in the facility where the contraband was found, including, but not limited to, cell, visiting room, common areas, or correctional employee dining facility;

(C) any method of entrance to the facility, including, but not limited to, correctional employee entrance, visitor entrance, vendor entrance, delivery person entrance, mail delivery, attorney visit, and other entrances to the facility;

(D) searches of persons and vehicles entering the facility; and

(E) type of contraband:
(i) drugs: specified by type or kind:
(I) item tested;
(II) test used; and
(III) test results (positive, negative, inconclusive, or unknown);
(ii) phones;
(iii) weapons; and
(iv) other contraband;
(F) number of instances or individuals caught possessing or attempting to procure or possess contraband:
(i) by facility; and
(ii) by designation of person within the facility such as staff or committed person;
(2) substance use disorder treatment or educational programming data by facility:
(A) available treatment programs indicating level of treatment: substance used education or intensive services;
(B) number of participants; and
(C) number of committed persons on waitlist;
(3) data regarding the use of naloxone by correctional employees and committed persons, excluding persons who administered the naloxone;
(4) data regarding emergency medical response and hospitalizations of individuals in custody:
(A) by facility;
(B) for what reason, including, for example, suspected drug overdose or exposure, injury inflicted by another person, environmental or workplace injury, or other; and
(C) by outcome:
(i) off-site emergency room visit;
(ii) off-site medical furlough;
(iii) total number of individuals in custody housed in outside hospitals;
(iv) total number of days individuals are housed in outside hospitals; and
(5) data regarding emergency medical response and hospitalizations of staff:
(A) by facility; and
(B) for what reason, including, for example, suspected drug overdose or exposure, injury inflicted by another person, environmental or workplace injury, or other.
The data described in paragraph (1) and subparagraph (A) of paragraphs (4) and (5) shall be collected beginning July 1, 2026 and shall be published annually on or before August 1 of each year. All other data described in paragraphs (2) through (5) shall be collected beginning July 1, 2027 and shall be published annually on or before August 1 of each year.

Section 99. Effective date. This Act takes effect July 1, 2026.".

AMENDMENT NO. 4 TO SENATE BILL 2201

AMENDMENT NO. 4 . Amend Senate Bill 2201, AS AMENDED, with reference to page and line numbers of House Amendment No. 3, on page 2, line 7, by deleting "and"; and

on page 2, line 22, by replacing "person;" with "person; and"; and

on page 2, by inserting immediately below line 22 the following:
"(G) number of referrals for prosecution for contraband brought into a correctional facility by staff and individuals in custody. Data shall be presented as a statewide aggregate and shall not identify any particular facility, county, or locality;".

Under the rules, the foregoing **Senate Bill No. 2201**, with House Amendments numbered 1, 3 and 4, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2153

A bill for AN ACT concerning regulation.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 3 to SENATE BILL NO. 2153

Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 3 TO SENATE BILL 2153

AMENDMENT NO. 3 . Amend Senate Bill 2153 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Physical Therapy Act is amended by changing Section 1.3 as follows:

(225 ILCS 90/1.3)

(Section scheduled to be repealed on January 1, 2026)

Sec. 1.3. Telehealth services.

(a) Physical therapy through telehealth services may be used to address access issues to care, enhance care delivery, or increase the physical therapist's ability to assess and direct the patient's performance in the patient's own environment.

(b) Only a ~~A~~ physical therapist or physical therapist assistant working under the general supervision of a physical therapist may provide physical therapy through telehealth services pursuant to the terms and use defined in the Telehealth Act and the Illinois Insurance Code and subject to the following conditions:

(1) Physical therapists may use telehealth to perform an initial physical therapy evaluation if one of the following criteria is met:

(i) the patient has a referral or diagnosis from a health care professional;

(ii) the patient has an established relationship with the physical therapist; or

(iii) the physical therapist has the capacity to perform or facilitate a referral for an in-person, hands-on examination or re-examination by a physical therapist at any time throughout the course of the patient's care, as needed. ~~Initial physical therapy evaluations without a referral or established diagnosis may only be performed by a licensed physical therapist and cannot be performed via telehealth unless necessary to address a documented hardship, including, but not limited to, geographical, physical, or weather related conditions.~~

(2) A physical therapist or a physical therapist assistant may require the patient to undergo an in-person visit instead of providing telehealth services. ~~The use of telehealth as a primary means of delivering physical therapy must be an exception and documentation must support the clinical justification.~~

(3) A patient receiving physical therapy via telehealth must be able to request and receive in-person care at any point during their treatment.

(4) A physical therapist providing telehealth must have the capacity to provide or be able to facilitate a referral to in-person care within the State of Illinois.

(5) A physical therapist or a physical therapist assistant may engage in the practice of telehealth services in this State to the extent of the physical therapist's or the physical therapist assistant's scope of practice as established in this Act and consistent with the standards of care for in-person services. This Section shall not be construed to authorize the delivery of physical therapy services in a setting or in a manner not otherwise authorized by law.

(6) A physical therapist or a physical therapist assistant working under the general supervision of a physical therapist treating a patient located in this State through telehealth services must be licensed or authorized to practice physical therapy in this State.

(c) The Department may, in consultation with the Department of Human Services and the Department of Early Childhood, exempt physical therapists and physical therapist assistants providing physical therapy services as part of the Illinois Early Intervention Program, an individualized education program, or a federal Section 504 plan through a school system from this Section by rule to address service delays.

(d) Nothing in this Section shall be construed to allow noncompliance with any requirements under the federal Individuals with Disabilities Education Act, the Early Intervention Services System Act, the Department of Early Childhood Act, or any other State or federal law or rules.

(Source: P.A. 103-849, eff. 1-1-25.)

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

Under the rules, the foregoing **Senate Bill No. 2153**, with House Amendment No. 3, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2215

A bill for AN ACT concerning State government.
Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:
House Amendment No. 1 to SENATE BILL NO. 2215
Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 2215

AMENDMENT NO. 1 . Amend Senate Bill 2215 by replacing everything after the enacting clause with the following:

"Section 5. The Department of Public Health Act is amended by adding Section 8.5 as follows:
(20 ILCS 2305/8.5 new)
Sec. 8.5. Information for distribution concerning fertility options.
(a) As used in this Section, "health care professional" means a physician licensed under the Medical Practice Act of 1987, a podiatrist licensed under the Podiatric Medical Practice Act of 1987, an advanced practice registered nurse licensed under the Nurse Practice Act, or a physician assistant licensed under the Physician Assistant Practice Act of 1987.
(b) The Department of Public Health shall provide the following clinical, evidence-based information to health care professionals that may be distributed to women over the age of 25 years, or women interested in information about future fertility, including, but not limited to:
(1) a description of the factors impacting fertility, including the ovarian reserve;
(2) an overview of different types of means to assess fertility, including ovarian reserve testing and the limitations of the tests; and
(3) information on potential results and resources that are available after testing and any additional information that should be considered by a patient undergoing the test.".

Under the rules, the foregoing **Senate Bill No. 2215**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2426

A bill for AN ACT concerning regulation.
Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:
House Amendment No. 1 to SENATE BILL NO. 2426
Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 2426

AMENDMENT NO. 1 . Amend Senate Bill 2426 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, 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 740/6) (from Ch. 96 1/2, par. 6913)

Sec. 6. Any person hauling or transporting timber that is subject to the Timber Buyers Licensing Act ~~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~~ 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) A person's proof of ownership shall be available for inspection at all times and shall be kept with the person's vehicle or other conveyance load.

(b) 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.

(c) 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.

Violations ~~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.)
(225 ILCS 740/5 rep.)

Section 15. The Forest Products Transportation Act is amended by repealing Sections 2.02, 2.03, 2.04, 2.05, 2.06, 2.07, and 5.

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.)".

Under the rules, the foregoing **Senate Bill No. 2426**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has adopted the following joint resolution, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

HOUSE JOINT RESOLUTION NO. 33

WHEREAS, It is highly fitting the Illinois General Assembly recognizes the sacrifice of U.S. Army Specialist Anthony "Tony" William Gilman and his love for his country; and

WHEREAS, Anthony Gilman, son of Fred and Mary Gilman, was born in Jerseyville on January 22, 1976; and

WHEREAS, Anthony Gilman grew up in Calhoun County, graduating from Calhoun High School in 1994; and

WHEREAS, Anthony Gilman enjoyed hunting and fishing throughout Calhoun and Pike County; and

WHEREAS, Anthony Gilman decided to enlist in the U.S. Army in 1997, making it to the rank of specialist; and

WHEREAS, Anthony Gilman lost his life on July 4, 1999, becoming the first American casualty during the peacekeeping mission in Kosovo; and

WHEREAS, The County of Calhoun is honoring the life and sacrifice of Anthony Gilman on Memorial Day 2025; therefore, be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE ONE HUNDRED FOURTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE SENATE CONCURRING HEREIN, that we designate Illinois Route 96 from Mozier to the Pike County line as "Army Specialist Anthony William Gilman Highway"; and be it further

RESOLVED, That the Illinois Department of Transportation is requested to erect, at suitable location consistent with State and Federal regulations, appropriate plaques or signs giving notice of the name of the "Army Specialist Anthony William Gilman Highway; and be it further

RESOLVED, That a suitable copy of this resolution be presented to the family of Army Specialist Anthony Gilman, the County Board of Calhoun, and the Secretary of Transportation.

Adopted by the House, May 28, 2025.

JOHN W. HOLLMAN, Clerk of the House

The foregoing message from the House of Representatives reporting House Joint Resolution No. 33 was referred to the Committee on Assignments.

At the hour of 7:20 o'clock p.m., Senator Aquino, presiding.

COMMITTEE MEETING ANNOUNCEMENTS

The Chair announced the following committees to meet at 7:30 o'clock p.m.:

Executive in Room 212
Licensed Activities in Room 400

State Government in Room 409

REPORTS FROM COMMITTEE ON ASSIGNMENTS

Senator Cunningham, Vice-Chair of the Committee on Assignments, during its May 29, 2025 meeting, reported the following Legislative Measure has been assigned to the indicated Standing Committee of the Senate:

Appropriations: **House Bill No. 111**.

Senator Cunningham, Vice-Chair of the Committee on Assignments, during its May 29, 2025 meeting, reported that **House Bill No. 111** has been re-referred from the Committee on Appropriations to the Committee on Assignments and has been approved for consideration by the Committee on Assignments.

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

At the hour of 7:23 o'clock p.m., the Chair announced that the Senate stands at recess subject to the call of the Chair.

AFTER RECESS

At the hour of 8:56 o'clock p.m., the Senate resumed consideration of business.

Senator Aquino, presiding.

REPORTS FROM STANDING COMMITTEES

Senator Castro, Chair of the Committee on Executive, to which was referred the Motion to Concur with House Amendment to the following Senate Bill, reported that the Committee recommends do adopt:

Motion to Concur in House Amendment No. 1 to Senate Bill 1994

Under the rules, the foregoing motion is eligible for consideration by the Senate.

Senator Castro, Chair of the Committee on Executive, to which was referred **House Bills Numbered 850 and 3247**, reported the same back with the recommendation that the bills do pass.

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

Senator Castro, Chair of the Committee on Executive, to which was referred **House Bill No. 3363**, 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 Castro, Chair of the Committee on Executive, to which was referred the following Senate floor amendments, reported that the Committee recommends do adopt:

Senate Amendment No. 2 to House Bill 2771
Senate Amendment No. 3 to House Bill 2785

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

Senator Glowiak Hilton, Chair of the Committee on Licensed Activities, to which was referred the Motions to Concur with House Amendments to the following Senate Bills, reported that the Committee recommends do adopt:

Motion to Concur in House Amendment No. 1 to Senate Bill 2431; Motion to Concur in House Amendment No. 2 to Senate Bill 2503; Motion to Concur in House Amendment No. 3 to Senate Bill 2503

Under the rules, the foregoing motions are eligible for consideration by the Senate.

Senator Joyce, Chair of the Committee on State Government, to which was referred the Motions to Concur with House Amendments to the following Senate Bills, reported that the Committee recommends do adopt:

Motion to Concur in House Amendment No. 1 to Senate Bill 58; Motion to Concur in House Amendment No. 1 to Senate Bill 314; Motion to Concur in House Amendment No. 1 to Senate Bill 1343; Motion to Concur in House Amendment No. 1 to Senate Bill 1548; Motion to Concur in House Amendment No. 1 to Senate Bill 1884; Motion to Concur in House Amendment No. 1 to Senate Bill 2108; Motion to Concur in House Amendment No. 3 to Senate Bill 2108

Under the rules, the foregoing motions are eligible for consideration by the Senate.

Senator Joyce, Chair of the Committee on State Government, to which was referred **House Bill No. 3140**, 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 the following Senate floor amendments, reported that the Committee recommends do adopt:

Senate Amendment No. 2 to House Bill 1631
Senate Amendment No. 1 to House Bill 3493

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

MESSAGES FROM THE HOUSE

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 1950

A bill for AN ACT concerning health.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 2 to SENATE BILL NO. 1950

Passed the House, as amended, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 1950

AMENDMENT NO. 2 . Amend Senate Bill 1950 by replacing everything after the enacting clause with the following:

"Section 1. Short title; references to Act.
(a) Short Title. This Act may be cited as the End-of-Life Options for Terminally Ill Patients Act.
(b) References to Act. This Act may be referred to as Deb's Law.

Section 5. Findings and intent.
(a) The General Assembly finds that:

(1) Medical aid in dying is part of general medical care and complements other end-of-life options, such as comfort care, pain control, palliative care, and hospice care, for individuals to have an end-of-life experience aligned with their beliefs and values.

(2) The availability of medical aid in dying provides an additional end-of-life care option for terminally ill individuals who seek to retain their autonomy and some level of control over the progression of the disease as they near the end of life or to ease unnecessary pain and suffering.

(3) Illinoisans facing a terminal diagnosis have been at the forefront of statewide efforts to provide the full range of end-of-life care options available in 10 states and the District of Columbia, to qualified mentally capable terminal adults residing in Illinois through the addition of medical aid-in-dying care as an end-of-life option in their home state. Advocates include:

(A) Deb Robertson, a lifelong Illinois resident who has been living with a rare form of her terminal illness, who wants to live but knows that she is going to die, and who has been actively engaged in advocacy to change Illinois law because she doesn't want to move to another state in order to access the end-of-life medical care that would bring her comfort and reduce her fear related to the pain of dying.

(B) Andrew Flack, who could not move back to Illinois to be with his family after his terminal diagnosis and instead had to live hundreds of miles away from his family, in a state that offered medical aid-in-dying care, in order to have a painless death surrounded by his loved ones.

(C) Miguel Carrasquillo, who despite enduring excruciatingly painful treatments to cure his cancer, which spread to his liver, stomach, testicles, and other organs, continued to advocate for a change in the law until his death, so other Illinoisans with a terminal diagnosis would not be forced to suffer at the end of their lives and die in pain as he did but would instead have the option of medical aid-in-dying care.

(4) Illinoisans throughout the State, across demographics, including religion, political affiliation, race, gender, disability, and age, also support the inclusion of medical aid-in-dying care in the options available for end-of-life care. Supporters and advocates recognize that mentally capable adult individuals have a fundamental right to determine their own medical treatment options in accordance with their own values, beliefs, or personal preferences, and having the option of medical aid in dying is an expression of this fundamental right. This includes advocates, like Lowell Sachnoff, who, alongside his wife Fay Clayton, was a tireless advocate for the expansion of end-of-life options for terminally ill adults over the course of a decade, up to and including the day he died.

(b) It is the intent of the General Assembly to uphold both the highest standard of medical care and the full range of options for each individual, particularly at the end of life.

Section 10. Definitions. As used in this Act:

"Adult" means an individual 18 years of age or older.

"Advanced practice registered nurse" means an advanced practice registered nurse licensed under the Nurse Practice Act who is certified as a psychiatric mental health practitioner.

"Aid in dying" means an end-of-life care option that allows a qualified patient to obtain a prescription for medication pursuant to this Act.

"Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

"Clinical psychologist" means a psychologist licensed under the Clinical Psychologist Licensing Act.

"Clinical social worker" means a person licensed under the Clinical Social Work and Social Work Practice Act.

"Coercion or undue influence" means the willful attempt, whether by deception, intimidation, or any other means to:

(1) cause a patient to request, obtain, or self-administer medication pursuant to this Act with intent to cause the death of the patient; or

(2) prevent a qualified patient, in a manner that conflicts with the Health Care Right of Conscience Act, from obtaining or self-administering medication pursuant to this Act.

"Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

"Department" means the Department of Public Health.

"Health care entity" means a hospital or hospital affiliate, nursing home, hospice or any other facility licensed under any of the following Acts: the Ambulatory Surgical Treatment Center Act; the Home Health, Home Services, and Home Nursing Agency Licensing Act; the Hospice Program Licensing Act; the Hospital Licensing Act; the Nursing Home Care Act; or the University of Illinois Hospital Act. "Health care entity" does not include a physician.

"Health care professional" means a physician, pharmacist, or licensed mental health professional.

"Informed decision" means a decision by a patient with mental capacity and a terminal disease to request and obtain a prescription for medication pursuant to this Act, that the qualified patient may self-administer to bring about a peaceful death, after being fully informed by the attending physician and consulting physician of:

(1) the patient's diagnosis and prognosis;

(2) the potential risks and benefits associated with taking the medication to be prescribed;

(3) the probable result of taking the medication to be prescribed;

(4) the feasible end-of-life care and treatment options for the patient's terminal disease, including, but not limited to, comfort care, palliative care, hospice care, and pain control, and the risks and benefits of each;

(5) the patient's right to withdraw a request pursuant this Act, or consent for any other treatment, at any time; and

(6) the patient's right to choose not to obtain the drug or to choose to obtain the drug but not to ingest it.

"Licensed mental health care professional" means a psychiatrist, clinical psychologist, clinical social worker, or advanced practice registered nurse.

"Mental capacity" means that, in the opinion of the attending physician or the consulting physician or, if the opinion of a licensed mental health care professional is required under Section 45, the licensed mental health care professional, the patient requesting medication pursuant to this Act has the ability to make and communicate an informed decision.

"Oral request" means an affirmative statement that demonstrates a contemporaneous affirmatively stated desire by the patient seeking aid in dying.

"Pharmacist" means an individual licensed to engage in the practice of pharmacy under the Pharmacy Practice Act.

"Physician" means a person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987.

"Psychiatrist" means a physician who has successfully completed a residency program in psychiatry accredited by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

"Qualified patient" means an adult Illinois resident with the mental capacity to make medical decisions who has satisfied the requirements of this Act in order to obtain a prescription for medication to bring about a peaceful death. No person will be considered a "qualified patient" under this Act solely because of advanced age, disability, or a mental health condition, including depression.

"Self-administer" means an affirmative, conscious, voluntary action, performed by a qualified patient, to ingest medication prescribed pursuant to this Act to bring about the patient's peaceful death. "Self-administer" does not include administration by parenteral injection or infusion.

"Terminal disease" means an incurable and irreversible disease that will, within reasonable medical judgment, result in death within 6 months. The existence of a terminal disease, as determined after in-person examination by the patient's physician and concurrence by another physician, shall be documented in writing in the patient's medical record. A diagnosis of a major depressive disorder, as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, alone does not qualify as a terminal disease.

Section 15. Informed consent.

(a) Nothing in this Act may be construed to limit the amount of information provided to a patient to ensure the patient can make a fully informed health care decision.

(b) An attending physician must provide sufficient information to a patient regarding all appropriate end-of-life care options, including comfort care, hospice care, palliative care, and pain control, as well as the foreseeable risks and benefits of each, so that the patient can make a voluntary and affirmative decision regarding the patient's end-of-life care.

(c) If a patient makes a request for the patient's medical records to be transmitted to an alternative physician, the patient's medical records shall be transmitted without undue delay.

Section 20. Standard of care. Nothing contained in this Act shall be interpreted to lower the applicable standard of care for the health care professionals participating under this Act.

Section 25. Qualification.

(a) A qualified patient with a terminal disease may request a prescription for medication under this Act in the following manner:

(1) The qualified patient may orally request a prescription for medication under this Act from the patient's attending physician.

(2) The oral request from the qualified patient shall be documented by the attending physician.

(3) The qualified patient shall provide a written request in accordance with this Act to the patient's attending physician after making the initial oral request.

(4) The qualified patient shall repeat the oral request to the patient's attending physician no less than 5 days after making the initial oral request.

(b) The attending and consulting physicians of a qualified patient shall have met all the requirements of Sections 35 and 40.

(c) Notwithstanding subsection (a), if the individual's attending physician has medically determined that the individual will, within reasonable medical judgment, die within 5 days after making the initial oral request under this Section, the individual may satisfy the requirements of this Section by providing a written request and reiterating the oral request to the attending physician at any time after making the initial oral request.

(d) At the time the patient makes the second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

(e) Oral and written requests for aid in dying may be made only by the patient and shall not be made by the patient's surrogate decision-maker, health care proxy, health care agent, attorney-in-fact for health care, guardian, nor via advance health care directive.

(f) If a requesting patient decides to transfer care to an alternative physician, the records custodian shall, upon written request, transmit, without undue delay, the patient's medical records, including written documentation of the dates of the patient's requests concerning aid in dying.

(g) A transfer of care or medical records does not toll or restart any waiting period.

Section 30. Form of written request.

(a) A written request for medication under this Act shall be in substantially the form under subsection (e), signed and dated by the requesting patient, and witnessed in the presence of the patient by at least 2 witnesses who attest that to the best of their knowledge and belief the patient has mental capacity, is acting voluntarily, and is not being coerced or unduly influenced to sign the request.

(b) One of the witnesses required under this Section must be a person who is not:

(1) a relative of the patient by blood, marriage, civil union, registered domestic partnership, or adoption;

(2) a person who, at the time the request is signed, would be entitled to any portion of the estate of the qualified patient upon death, under any will or by operation of law; or

(3) an owner, operator, or employee of a health care entity where the qualified patient is receiving medical treatment or is a resident.

(c) The patient's attending physician at the time the request is signed shall not be a witness.

(d) If a person uses an interpreter, the interpreter shall not be a witness.

(e) The written request for medication under this Act shall be substantially as follows:

"Request for Medication to End My Life in a Peaceful Manner

I, ... (NAME OF PATIENT), am an adult of sound mind, and a resident of Illinois. I have been diagnosed with ..... (NAME OF CONDITION) and given a terminal disease prognosis of 6 months or less to live by my attending physician.

I affirm that my terminal disease diagnosis was given or confirmed during at least one in-person visit to a health care professional.

I have been fully informed of the feasible alternatives and concurrent or additional treatment opportunities for my terminal disease, including, but not limited to, comfort care, palliative care, hospice care, or pain control, as well as the potential risks and benefits of each. I have been offered, have received, or have been offered and received resources or referrals to pursue these alternatives and concurrent or additional treatment opportunities for my terminal disease.

I have been fully informed of the nature of the medication to be prescribed, including the risks and benefits, and I understand that the likely outcome of self-administering the medication is death.

I understand that I can rescind this request at any time, that I am under no obligation to fill the prescription once written, and that I have no duty to self-administer the medication if I obtain it.

I request that my attending physician furnish a prescription for medication that will end my life if I choose to self-administer it, and I authorize my attending physician to transmit the prescription to a pharmacist to dispense the medication at a time of my choosing.

I make this request voluntarily, free from coercion or undue influence.

Dated: .....

Signed.....

(patient)

Dated: .....

Signed.....

(witness #1)

Dated: .....

Signed.....

(witness #2)"

(f) The interpreter attachment for a written request for medication under this Act shall be substantially as follows:

"Request for Medication to End My Life in a Peaceful Manner
Interpreter Attachment

I, ... (NAME OF INTERPRETER), am fluent in English and ..... (LANGUAGE OF PATIENT, INCLUDING SIGN LANGUAGE).

On ..... (DATE) at approximately ..... (TIME), I read the "Request for Medication to End My Life in a Peaceful Manner" form to ..... (NAME OF PATIENT) in ..... (LANGUAGE OF PATIENT, INCLUDING SIGN LANGUAGE).

..... (NAME OF PATIENT) affirmed to me that they understand the content of this form, that they desire to sign this form under their own power and volition, and that they requested to sign the form after consultations with an attending physician.

Under penalty of perjury, I declare that I am fluent in English and ..... (LANGUAGE OF PATIENT, INCLUDING SIGN LANGUAGE) and that the contents of this form, to the best of my knowledge, are true and correct. Executed at ..... (NAME OF CITY, COUNTY, AND STATE) on ..... (DATE).

Interpreter's signature: .....

Interpreter's printed name: ....

Interpreter's address: ....".

Section 35. Attending physician responsibilities.

(a) Following the request of a patient for aid in dying, the attending physician shall conduct an evaluation of the patient and:

(1) determine whether the patient has a terminal disease or has been diagnosed as having a terminal disease;

(2) determine whether a patient has mental capacity;

(3) confirm that the patient's request does not arise from coercion or undue influence;

(4) inform the patient of:

(A) the diagnosis;

(B) the prognosis;

(C) the potential risks, benefits, and probable result of self-administering the prescribed medication to bring about a peaceful death;

(D) the potential benefits and risks of feasible alternatives, including, but not limited to, concurrent or additional treatment options for the patient's terminal disease, comfort care, palliative care, hospice care, and pain control; and

(E) the patient's right to rescind the request for medication pursuant to this Act at any time;

(5) inform the patient that there is no obligation to fill the prescription nor an obligation to self-administer the medication, if it is obtained;

(6) provide the patient with a referral for comfort care, palliative care, hospice care, pain control, or other end-of-life treatment options as requested by the patient and as clinically indicated;

(7) refer the patient to a consulting physician for medical confirmation that the patient requesting medication pursuant to this Act:

(A) has a terminal disease with a prognosis of 6 months or less to live; and

(B) has mental capacity.

(8) include the consulting physician's written determination in the patient's medical record;

(9) refer the patient to a licensed mental health professional in accordance with Section 45 if the attending physician observes signs that the individual may not be capable of making an informed decision;

(10) include the licensed mental health professional's written determination in the patient's medical record, if such determination was requested;

(11) inform the patient of the benefits of notifying the next of kin of the patient's decision to request medication pursuant to this Act;

(12) fulfill the medical record documentation requirements;

(13) ensure that all steps are carried out in accordance with this Act before providing a prescription to a qualified patient for medication pursuant to this Act including:

(A) confirming that the patient has made an informed decision to obtain a prescription for medication;

(B) offering the patient an opportunity to rescind the request for medication; and

(C) providing information to the patient on:

(i) the recommended procedure for self-administering the medication to be prescribed;

(ii) the safekeeping and proper disposal of unused medication in accordance with State and federal law;

(iii) the importance of having another person present when the patient self-administers the medication to be prescribed; and

(iv) not taking the aid-in-dying medication in a public place;

(14) deliver, in accordance with State and federal law, the prescription personally, by mail, or through an authorized electronic transmission to a licensed pharmacist who will dispense the medication, including any ancillary medications, to the qualified patient, or to a person expressly designated by the qualified patient in person or with a signature required on delivery, by mail service, or by messenger service;

(15) if authorized by the Drug Enforcement Administration, dispense the prescribed medication, including any ancillary medications, to the qualified patient or a person designated by the qualified patient; and

(16) include, in the qualified patient's medical record, the patient's diagnosis and prognosis, determination of mental capacity, the date of each oral request, a copy of the written request, a notation that the requirements under this Section have been completed, and an identification of the medication and ancillary medications prescribed to the qualified patient pursuant to this Act.

(b) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate.

Section 40. Consulting physician responsibilities. A consulting physician shall:

(1) conduct an evaluation of the patient and review the patient's relevant medical records, including the evaluation pursuant to Section 45, if such evaluation was necessary;

(2) confirm in writing to the attending physician that the patient:

(A) has requested a prescription for aid-in-dying medication;

(B) has a documented terminal disease;

(C) has mental capacity or has provided documentation that the consulting health care professional has referred the individual for further evaluation in accordance with Section 45; and

(D) is acting voluntarily, free from coercion or undue influence.

Section 45. Referral for determination that the requesting patient has mental capacity.

(a) If either the attending physician or the consulting physician has doubts whether the individual has mental capacity and if either one is unable to confirm that the individual is capable of making an informed decision, the attending physician or consulting physician shall refer the patient to a licensed mental health professional for determination regarding mental capability.

(b) The licensed mental health professional shall additionally determine whether the patient is suffering from a psychiatric or psychological disorder causing impaired judgment.

(c) The licensed mental health professional who evaluates the patient under this Section shall submit to the requesting attending or consulting physician a written determination of whether the patient has mental capacity.

(d) If the licensed mental health professional determines that the patient does not have mental capacity, or is suffering from a psychiatric or psychological disorder causing impaired judgment, the patient shall not be deemed a qualified patient and the attending physician shall not prescribe medication to the patient under this Act.

Section 50. Residency requirement.

(a) Only requests made by Illinois residents may be granted under this Act.

(b) A patient is able to establish residency through any one or more of the following means:

(1) possession of a driver's license or other identification issued by the Secretary of State or State of Illinois;

(2) registration to vote in Illinois;

(3) evidence that the person owns, rents, or leases property in Illinois;

(4) the location of any dwelling occupied by the person;

(5) the place where any motor vehicle owned by the person is registered;

(6) the residence address, not a post office box, shown on an income tax return filed for the year preceding the year in which the person initially makes an oral request under this Act;

(7) the residence address, not a post office box, at which the person's mail is received;

(8) the residence address, not a post office box, shown on any unexpired resident hunting or fishing or other licenses held by the person;

(9) the receipt of any public benefit conditioned upon residency; or

(10) any other objective facts tending to indicate a person's place of residence is in Illinois.

Section 55. Safe disposal of unused medications. A person who has custody or control of medication prescribed pursuant to this Act after the qualified patient's death shall dispose of the medication by delivering it to the nearest qualified facility that properly disposes of controlled substances or, if none is available, by lawful means in accordance with applicable State and federal guidelines.

Section 60. Health care professional protections; no duty to provide aid in dying.

(a) A health care professional shall not be under any duty, by law or contract, to participate in the provision of aid-in-dying care to a patient as set forth in this Act.

(b) A health care professional shall not be subject to civil or criminal liability for participating or refusing to participate in the provision of aid-in-dying care to a patient in good faith compliance with this Act.

(c) Except as set forth in Section 65, a health care entity or licensing board shall not subject a health care professional to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in accordance with this Act.

(d) A health care professional may choose not to engage in aid-in-dying care.

(e) Only willing health care professionals shall provide aid-in-dying care in accordance with this Act. If a health care professional is unable or unwilling to carry out a patient's request under this Act, and the

patient transfers the patient's care to a new health care professional, the prior health care professional shall transmit, upon request, a copy of the patient's relevant medical records to the new health care professional without undue delay.

(f) A health care professional shall not engage in false, misleading, or deceptive practices relating to a willingness to qualify a patient or provide aid-in-dying care. Intentionally misleading a patient constitutes coercion or undue influence.

(g) The provisions of the Health Care Right of Conscience Act apply to this Act and are incorporated by reference.

Section 65. Health care entity protections and permissible prohibitions and duties.

(a) A health care entity shall not be under any duty, by law or contract, to participate in the provision of aid-in-dying care to a patient as set forth in this Act.

(b) A health care entity shall not be subject to civil or criminal liability for participating or refusing to participate in the provision of aid-in-dying care to a patient in good faith compliance with this Act.

(c) A health care entity may prohibit health care professionals, staff, employees, or independent contractors, from practicing aid-in-dying care while performing duties for the entity. A prohibiting entity must provide advance notice in writing to health care professionals and staff at the time of hiring, contracting with, or privileging and on a yearly basis thereafter. Such policies prohibiting aid-in-dying care may include provisions for the health care entity to take disciplinary action, including, but not limited to, termination for those employees, independent contractors, and staff who violate the health care entity's policies, consistent with existing disciplinary policies.

(d) If a patient wishes to transfer care to another health care entity, the prohibiting entity shall coordinate a timely transfer of care, including transmitting, without undue delay, the patient's medical records.

(e) No health care entity shall prohibit a health care professional from:

(1) providing information to a patient regarding the patient's health status, including, but not limited to, diagnosis, prognosis, recommended treatment and treatment alternatives, and the risks and benefits of each;

(2) providing information regarding health care services available pursuant to this Act, information about relevant community resources, and how to access those resources for obtaining care of the patient's choice;

(3) practicing aid-in-dying care outside the scope of the health care professional's employment or contract with the prohibiting entity and off the premises of the prohibiting entity; provided, however, that in such event the health care professional shall explicitly tell the patient that such health care professional is providing such services independently and not as a representative of their associated health care entity; or

(4) being present, if outside the scope of the health care professional's employment or contractual duties, when a qualified patient self-administers medication prescribed pursuant to this Act or at the time of death, if requested by the qualified patient or their representative.

(f) A health care entity shall not engage in false, misleading, or deceptive practices relating to its policy around end-of-life care services, including whether it has a policy that prohibits affiliated health care professionals from practicing aid-in-dying care; or intentionally denying a patient access to medication pursuant to this Act by intentionally failing to transfer a patient and the patient's medical records to another health care professional in a timely manner. Intentionally misleading a patient or deploying misinformation to obstruct access to services pursuant to this Act constitutes coercion or undue influence.

(g) The provisions of the Health Care Right of Conscience Act apply to this Act and are incorporated by reference.

(h) If any part of this Section is found to be in conflict with federal requirements which are a prescribed condition to receipt of federal funds, the conflicting part of this Section is inoperative solely to the extent of the conflict with respect to the entity directly affected, and such finding or determination shall not affect the operation of the remainder of the Section or this Act.

Section 70. Immunities for actions in good faith; prohibition against reprisals.

(a) Except as set forth in Section 65, a health care professional or health care entity shall not be subject to civil or criminal liability, licensing sanctions, or other professional disciplinary action for actions taken in good faith compliance with this Act.

(b) If a health care professional or health care entity is unable or unwilling to carry out an individual's request for aid in dying, the professional or entity shall, at a minimum:

(1) inform the individual of the professional's or entity's inability or unwillingness;

(2) refer the individual either to a health care professional who is able and willing to evaluate and qualify the individual or to another individual or entity to assist the requesting individual in seeking aid in dying, in accordance with the Health Care Right of Conscience Act; and

(3) note, in the medical record, the individual's date of request and health care professional's notice to the individual of the health care professional's unwillingness or inability to carry out the individual's request.

(c) Except as set forth in Section 65, a health care entity or licensing board shall not subject a health care professional to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for engaging in good faith compliance with this Act.

(d) Except as set forth in Section 65, a health care professional, health care entity, or licensing board shall not subject a health care professional to discharge, demotion, censure, discipline, suspension, loss of license, loss of privileges, loss of membership, discrimination, or any other penalty for providing aid-in-dying care in accordance with the standard of care and in good faith under this Act when:

(1) engaged in the outside practice of medicine and off of the objecting health care entity's premises; or

(2) providing scientific and accurate information about aid-in-dying care to a patient when discussing end-of-life care options.

(e) A physician is not subject to civil or criminal liability or professional discipline if, at the request of the qualified patient, the physician is present outside the scope of the physician's employment contract and off the entity's premises, when the qualified patient self-administers medication pursuant to this Act, or at the time of death.

(f) A physician who is present at self-administration may, without civil or criminal liability, assist the qualified patient by preparing the medication prescribed pursuant to this Act.

(g) A request by a patient for aid in dying does not alone constitute grounds for neglect or elder abuse for any purpose of law, nor shall it be the sole basis for appointment of a guardian.

(h) This Section does not limit civil liability for intentional misconduct.

Section 75. Reporting requirements.

(a) Within 45 days after the effective date of this Act, the Department shall create and post to its website an Attending Physician Checklist Form and Attending Physician Follow-Up Form to facilitate collection of the information described in this Section. Failure to create or post the Attending Physician Checklist Form, the Attending Physician Follow-Up Form, or both shall not suspend the effective date of this Act.

(b) Within 30 calendar days of providing a prescription for medication pursuant to this Act, the attending physician shall submit to the Department an Attending Physician Checklist Form with the following information:

(1) the qualifying patient's name and date of birth;

(2) the qualifying patient's terminal diagnosis and prognosis;

(3) notice that the requirements under this Act were completed; and

(4) notice that medication has been prescribed pursuant to this Act.

(c) Within 60 calendar days of notification of a qualified patient's death from self-administration of medication prescribed pursuant to this Act, the attending physician shall submit to the Department, an Attending Physician Follow-Up Form with the following information:

(1) the qualified patient's name and date of birth;

(2) the date of the qualified patient's death; and

(3) a notation of whether the qualified patient was enrolled in hospice services at the time of the qualified patient's death.

(d) The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any health care professional involved with the patient under the provisions of this Act. The information shall be privileged and strictly confidential, and shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(e) One year after the effective date of this Act, and each year thereafter, the Department shall create and post on its website a public statistical report of nonidentifying information. The report shall be limited to:

(1) the number of prescriptions for medication written pursuant to this Act;

(2) the number of physicians who wrote prescriptions for medication pursuant to this Act;

(3) the number of qualified patients who died following self-administration of medication prescribed and dispensed pursuant to this Act; and

(4) the number of people who died due to using an aid-in-dying drug, with demographic percentages organized by the following characteristics as aggregated and de-identified data sets:

(A) age at death;

(B) education level;

(C) race;

(D) gender;

(E) type of insurance, including whether the patient had insurance;

(F) underlying illness; and

(G) enrollment in hospice.

(f) Except as otherwise required by law, the information collected by the Department is not a public record, is not available for public inspection, and is not available through the Freedom of Information Act.

(g) Willful failure or refusal to timely submit records required under this Act may result in disciplinary action.

Section 80. Effect on construction of wills, contracts, and statutes.

(a) No provision in a contract, will, or other agreement, whether written or oral, that would determine whether a patient may make or rescind a request pursuant to this Act is valid.

(b) No obligation owing under any contract that is in effect on the effective date of this Act shall be conditioned or affected by a patient's act of making or rescinding a request pursuant to this Act.

(c) It is unlawful for an insurer to deny or alter health care benefits otherwise available to a patient with a terminal disease based on the availability of aid-in-dying care or otherwise attempt to coerce a patient with a terminal disease to make a request for aid-in-dying medication.

(d) Nothing in this Act prevents an insurer from exercising any right to void a policy based on a material misrepresentation, as provided under Section 154 of the Illinois Insurance Code, in an application for insurance.

Section 85. Insurance or annuity policies.

(a) The sale, procurement, or issuance of a life, health, or accident insurance policy, annuity policy, or the rate charged for a policy shall not be conditioned upon or affected by a patient's act of making or rescinding a request for medication pursuant to this Act.

(b) A qualified patient's act of self-administering medication pursuant to this Act does not invalidate any part of a life, health, or accident insurance, or annuity policy.

(c) An insurance plan, including medical assistance under Article V of the Illinois Public Aid Code, shall not deny or alter benefits to a patient with a terminal disease who is a covered beneficiary of a health insurance plan, based on the availability of aid-in-dying care, their request for medication pursuant to this Act, or the absence of a request for medication pursuant to this Act. Failure to meet this requirement shall constitute a violation of the Illinois Insurance Code.

(d) The Department of Insurance shall enforce the provisions of this Act with respect to any life, health, or accident insurance policy or annuity policy pursuant to the enforcement powers granted to it by law. A violation of this Act by any person or entity under the jurisdiction of the Department of Insurance shall be deemed a violation of the relevant provisions of the Illinois Insurance Code under which the person or entity is authorized to transact business in this State.

(e) For the purposes of this Act, "life, health, or accident insurance policy or annuity policy" means any insurance under Class 1(a), 1(b), or 2(a) of the Illinois Insurance Code, a health care plan under the Health Maintenance Organization Act, a limited health care plan under the Limited Health Service Organization Act, a dental service plan under the Dental Service Plans Act, or a voluntary health services plan under the Voluntary Health Services Plan Act.

Section 90. Death certificate.

(a) Unless otherwise prohibited by law, the attending physician may sign the death certificate of a qualified patient who obtained and self-administered a prescription for medication pursuant to this Act.

(b) When a death has occurred in accordance with this Act, the death shall be attributed to the underlying terminal disease.

(1) Death following self-administering medication under this Act does not alone constitute grounds for postmortem inquiry.

(2) Death in accordance with this Act shall not be designated a suicide or homicide.

(c) A qualified patient's act of self-administering medication prescribed pursuant to this Act shall not be indicated on the death certificate.

Section 95. Liabilities and penalties.

(a) Nothing in this Act limits civil or criminal liability arising from:

(1) Intentionally or knowingly altering or forging a patient's request for medication pursuant to this Act or concealing or destroying a rescission of a request for medication pursuant to this Act.

(2) Intentionally or knowingly coercing or exerting undue influence on a patient with a terminal disease to request medication pursuant to this Act or to request or use or not use medication pursuant to this Act.

(3) Intentional misconduct by a health care professional or health care entity.

(b) The penalties specified in this Act do not preclude criminal penalties applicable under other laws for conduct inconsistent with this Act.

(c) As used in this Section, "intentionally" and "knowingly" have the meanings provided in Sections 4-4 and 4-5 of the Criminal Code of 2012.

Section 100. Construction.

(a) Nothing in this Act authorizes a physician or any other person, including the qualified patient, to end the qualified patient's life by lethal injection, lethal infusion, mercy killing, homicide, murder, manslaughter, euthanasia, or any other criminal act.

(b) Actions taken in accordance with this Act do not, for any purposes, constitute suicide, assisted suicide, euthanasia, mercy killing, homicide, murder, manslaughter, elder abuse or neglect, or any other civil or criminal violation under the law.

Section 105. Rulemaking Authority. The Department of Public Health and the Department of Veterans Affairs may adopt rules for the implementation and administration of this Act.

Section 110. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 200. The Freedom of Information Act is amended by changing Section 7.5 as follows:

(5 ILCS 140/7.5)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmitted infection or any information the disclosure of which is restricted under the Illinois Sexually Transmitted Infection Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act (repealed). This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Department of Transportation under Sections 2705-300 and 2705-616 of the Department of Transportation Law of the Civil Administrative Code of Illinois, the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act, or the St. Clair County Transit District under the Bi-State Transit Safety Act (repealed).

(q) Information prohibited from being disclosed by the Personnel Record Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) (Blank).

(u) Records and information provided to an independent team of experts under the Developmental Disability and Mental Health Safety Act (also known as Brian's Law).

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(v-5) Records of the Firearm Owner's Identification Card Review Board that are exempted from disclosure under Section 10 of the Firearm Owners Identification Card Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) Records that are exempt from disclosure under Section 1A-16.7 of the Election Code.

(ii) Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(kk) Information prohibited from disclosure under the Seizure and Forfeiture Reporting Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(mm) Records that are exempt from disclosure under Section 4.2 of the Crime Victims Compensation Act.

(nn) Information that is exempt from disclosure under Section 70 of the Higher Education Student Assistance Act.

(oo) Communications, notes, records, and reports arising out of a peer support counseling session prohibited from disclosure under the First Responders Suicide Prevention Act.

(pp) Names and all identifying information relating to an employee of an emergency services provider or law enforcement agency under the First Responders Suicide Prevention Act.

(qq) Information and records held by the Department of Public Health and its authorized representatives collected under the Reproductive Health Act.

(rr) Information that is exempt from disclosure under the Cannabis Regulation and Tax Act.

(ss) Data reported by an employer to the Department of Human Rights pursuant to Section 2-108 of the Illinois Human Rights Act.

(tt) Recordings made under the Children's Advocacy Center Act, except to the extent authorized under that Act.

(uu) Information that is exempt from disclosure under Section 50 of the Sexual Assault Evidence Submission Act.

(vv) Information that is exempt from disclosure under subsections (f) and (j) of Section 5-36 of the Illinois Public Aid Code.

(ww) Information that is exempt from disclosure under Section 16.8 of the State Treasurer Act.

(xx) Information that is exempt from disclosure or information that shall not be made public under the Illinois Insurance Code.

(yy) Information prohibited from being disclosed under the Illinois Educational Labor Relations Act.

(zz) Information prohibited from being disclosed under the Illinois Public Labor Relations Act.

(aaa) Information prohibited from being disclosed under Section 1-167 of the Illinois Pension Code.

(bbb) Information that is prohibited from disclosure by the Illinois Police Training Act and the Illinois State Police Act.

(ccc) Records exempt from disclosure under Section 2605-304 of the Illinois State Police Law of the Civil Administrative Code of Illinois.

(ddd) Information prohibited from being disclosed under Section 35 of the Address Confidentiality for Victims of Domestic Violence, Sexual Assault, Human Trafficking, or Stalking Act.

(eee) Information prohibited from being disclosed under subsection (b) of Section 75 of the Domestic Violence Fatality Review Act.

(fff) Images from cameras under the Expressway Camera Act. This subsection (fff) is inoperative on and after July 1, 2025.

(ggg) Information prohibited from disclosure under paragraph (3) of subsection (a) of Section 14 of the Nurse Agency Licensing Act.

(hhh) Information submitted to the Illinois State Police in an affidavit or application for an assault weapon endorsement, assault weapon attachment endorsement, .50 caliber rifle endorsement, or .50 caliber cartridge endorsement under the Firearm Owners Identification Card Act.

(iii) Data exempt from disclosure under Section 50 of the School Safety Drill Act.

(jjj) Information exempt from disclosure under Section 30 of the Insurance Data Security Law.

(kkk) Confidential business information prohibited from disclosure under Section 45 of the Paint Stewardship Act.

(lll) Data exempt from disclosure under Section 2-3.196 of the School Code.

(mmm) Information prohibited from being disclosed under subsection (e) of Section 1-129 of the Illinois Power Agency Act.

(nnn) Materials received by the Department of Commerce and Economic Opportunity that are confidential under the Music and Musicians Tax Credit and Jobs Act.

(ooo) Data or information provided pursuant to Section 20 of the Statewide Recycling Needs and Assessment Act.

(ppp) Information that is exempt from disclosure under Section 28-11 of the Lawful Health Care Activity Act.

(qqq) Information that is exempt from disclosure under Section 7-101 of the Illinois Human Rights Act.

(rrr) Information prohibited from being disclosed under Section 4-2 of the Uniform Money Transmission Modernization Act.

(sss) Information exempt from disclosure under Section 40 of the Student-Athlete Endorsement Rights Act.

(ttt) Audio recordings made under Section 30 of the Illinois State Police Act, except to the extent authorized under that Section.

(uuu) Information exempt from disclosure under Section 70 of the End-of-Life Options for Terminally Ill Patients Act.

(Source: P.A. 102-36, eff. 6-25-21; 102-237, eff. 1-1-22; 102-292, eff. 1-1-22; 102-520, eff. 8-20-21; 102-559, eff. 8-20-21; 102-813, eff. 5-13-22; 102-946, eff. 7-1-22; 102-1042, eff. 6-3-22; 102-1116, eff. 1-10-23; 103-8, eff. 6-7-23; 103-34, eff. 6-9-23; 103-142, eff. 1-1-24; 103-372, eff. 1-1-24; 103-472, eff. 8-1-24; 103-508, eff. 8-4-23; 103-580, eff. 12-8-23; 103-592, eff. 6-7-24; 103-605, eff. 7-1-24; 103-636, eff. 7-1-24; 103-724, eff. 1-1-25; 103-786, eff. 8-7-24; 103-859, eff. 8-9-24; 103-991, eff. 8-9-24; 103-1049, eff. 8-9-24; 103-1081, eff. 3-21-25.)

Section 999. Effective date. This Act takes effect 9 months after becoming law.".

Under the rules, the foregoing **Senate Bill No. 1950**, with House Amendment No. 2, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has passed a bill of the following title, in the passage of which I am instructed to ask the concurrence of the Senate, to-wit:

HOUSE BILL NO. 1505

A bill for AN ACT concerning gaming.

Passed the House, April 8, 2025.

JOHN W. HOLLMAN, Clerk of the House

The foregoing **House Bill No. 1505** was taken up, ordered printed and placed on first reading.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of bills of the following titles, to-wit:

SENATE BILL NO. 100

A bill for AN ACT concerning gaming.

SENATE BILL NO. 406

A bill for AN ACT concerning education.

SENATE BILL NO. 1418

A bill for AN ACT concerning regulation.

Passed the House, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the adoption of the following joint resolution, to-wit:

SENATE JOINT RESOLUTION NO. 25

Concurred in by the House, May 29, 2025.

JOHN W. HOLLMAN, Clerk of the House

READING BILL FROM THE HOUSE OF REPRESENTATIVES A FIRST TIME

House Bill No. 1505, sponsored by Senator Cunningham, was taken up, read by title a first time and referred to the Committee on Assignments.

LEGISLATIVE MEASURES FILED

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

Amendment No. 2 to House Bill 1224

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

Amendment No. 1 to Senate Bill 1977

JOINT ACTION MOTION FILED

The following Joint Action Motion to the Senate Bill listed below has been filed with the Secretary and referred to the Committee on Assignments:

Motion to Concur in House Amendment No. 1 to Senate Bill 1922

At the hour of 8:59 o'clock p.m., the Chair announced that the Senate stands adjourned until Friday, May 30, 2025, at 11:00 o'clock a.m.