SB2405

LRB10410637BABAB20714b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB2405

Introduced 2/7/2025, by Sen. Ram Villivalam

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a	
215 ILCS 5/370g	from Ch. 73, par. 982g
215 ILCS 125/4-15	from Ch. 111 1/2, par. 1409.8
815 ILCS 505/2HHHH new	

Amends the Illinois Insurance Code to create the Consumer Protection from Surprise Health Care Billing Act. Provides that, on or after July 1, 2025, notwithstanding any other applicable provision, when a beneficiary, insured, or enrollee receives services from a nonparticipating ground ambulance service provider, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating ground ambulance service provider. Provides that any cost-sharing requirements shall be applied as though the services provided by the nonparticipating ground ambulance service provider had been provided by a participating ground ambulance service provider. Sets forth provisions concerning payment for ground ambulance services; calculating the recognized amount; limitations for the cost sharing amount for any occurrence in which a ground ambulance service is provided to a beneficiary; appeals for payments made by health insurance issuers; the maximum allowable payment amounts, by individual service types, for nonparticipating ground ambulance service providers owned, operated, or controlled by a private organization; and payments to nonparticipating ground ambulance service providers owned, operated, or controlled, by a unit of government which participates in the Ground Emergency Medical Transportation program administered by the Department of Healthcare and Family Services. Makes conforming changes. Provides that the failure by a health insurance issuer to comply with the specified requirements constitutes an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act and enforcement authority is granted to the Attorney General. Amends the Health Maintenance Organization Act and the Consumer Fraud and Deceptive Business Practices Act to make corresponding changes. Effective July 1, 2025.

LRB104 10637 BAB 20714 b

A BILL FOR

AN ACT concerning regulation.

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

Section 1. This Act may be cited as the Consumer Protection from Surprise Health Care Billing Act.

Section 2. The General Assembly finds that:

(1) Consumers, health insurance issuers, health care providers, and government bodies will benefit from clearly articulated consumer protections against surprise health care billing.

(2) Surprise health care bills contribute substantially to high levels of medical debt for consumers in Illinois.

(3) Ground ambulance services are a necessity for patients and patients' positive health outcomes and should not be the cause for surprise health care bills.

(4) Consumers should be protected from being in the middle of billing disputes between health insurance issuers and health care providers.

Section 3. The purpose of this Act is to protect patients from surprise medical bills when receiving certain emergency services and non-emergency services from out-of-network

providers.

Section 5. The Illinois Insurance Code is amended by changing Sections 356z.3a and 370g as follows:

(215 ILCS 5/356z.3a)

Sec. 356z.3a. Billing; emergency services; nonparticipating providers.

(a) As used in this Section:

"Ancillary services" means:

(1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology that are provided by any health care provider;

(2) items and services provided by assistant surgeons, hospitalists, and intensivists;

(3) diagnostic services, including radiology and laboratory services, except for advanced diagnostic laboratory tests identified on the most current list published by the United States Secretary of Health and Human Services under 42 U.S.C. 300gg-132(b)(3);

(4) items and services provided by other specialty practitioners as the United States Secretary of Health and Human Services specifies through rulemaking under 42 U.S.C. 300gg-132(b)(3);

(5) items and services provided by a nonparticipating provider if there is no participating provider who can

furnish the item or service at the facility; and

(6) items and services provided by a nonparticipating provider if there is no participating provider who will furnish the item or service because a participating provider has asserted the participating provider's rights under the Health Care Right of Conscience Act.

"Cost sharing" means the amount an insured, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the policy or certificate. "Cost sharing" includes copayments, coinsurance, and amounts paid toward deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the policy or certificate.

"Emergency department of a hospital" means any hospital department that provides emergency services, including a hospital outpatient department.

"Emergency medical condition" has the meaning ascribed to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency medical screening examination" has the meaning ascribed to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency services" means, with respect to an emergency medical condition:

(1) in general, an emergency medical screening

examination, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment as would be required to stabilize the patient regardless of the department of the hospital or other facility in which such further examination or treatment is furnished; or

(2) additional items and services for which benefits are provided or covered under the coverage and that are furnished by a nonparticipating provider or nonparticipating emergency facility regardless of the department of the hospital or other facility in which such items are furnished after the insured, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (1) are furnished. Services after stabilization cease to be emergency services only when all the conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and regulations thereunder are met.

"Freestanding Emergency Center" means a facility licensed under Section 32.5 of the Emergency Medical Services (EMS) Systems Act.

"Ground ambulance service" means both medical transportation services that are described as ground ambulance services by the Centers for Medicare and Medicaid Services and

medical non-transportation services such as evaluation without transport, treatment without transport, or paramedic intercept that are either provided in a vehicle that is licensed as an ambulance under the Emergency Medical Services (EMS) Systems Act or provided by EMS Personnel assigned to a vehicle that is licensed as an ambulance under the Emergency Medical Services (EMS) Systems Act.

"Ground ambulance service provider" means a vehicle service provider under the Emergency Medical Services (EMS) Systems Act that operates licensed ground ambulances for the purpose of providing emergency ambulance services, non-emergency ambulance services, or both. "Ground ambulance service provider" includes both ambulance providers and ambulance suppliers as described by the Centers for Medicare and Medicaid Services.

"Health care facility" means, in the context of non-emergency services, any of the following:

(1) a hospital as defined in 42 U.S.C. 1395x(e);

(2) a hospital outpatient department;

(3) a critical access hospital certified under 42 U.S.C. 1395i-4(e);

(4) an ambulatory surgical treatment center as defined in the Ambulatory Surgical Treatment Center Act; or

(5) any recipient of a license under the Hospital Licensing Act that is not otherwise described in this definition.

"Health care provider" means a provider as defined in subsection (d) of Section 370g. "Health care provider" does not include a provider of air ambulance or ground ambulance services.

"Health care services" has the meaning ascribed to that term in subsection (a) of Section 370g.

"Health insurance issuer" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Nonparticipating emergency facility" means, with respect to the furnishing of an item or service under a policy of group or individual health insurance coverage, any of the following facilities that does not have a contractual relationship directly or indirectly with a health insurance issuer in relation to the coverage:

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

(3) an ambulatory surgical treatment center as defined in the Ambulatory Surgical Treatment Center Act; or

(4) with respect to emergency services described in paragraph (2) of the definition of "emergency services", a hospital.

"Nonparticipating provider" means, with respect to the furnishing of an item or service under a policy of group or individual health insurance coverage, any health care provider who does not have a contractual relationship directly or

indirectly with a health insurance issuer in relation to the coverage.

"Participating emergency facility" means any of the following facilities that has a contractual relationship directly or indirectly with a health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant health care service is provided to an insured, beneficiary, or enrollee under the coverage:

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

(3) an ambulatory surgical treatment center as defined in the Ambulatory Surgical Treatment Center Act; or

(4) with respect to emergency services described in paragraph (2) of the definition of "emergency services", a hospital.

For purposes of this definition, a single case agreement between an emergency facility and an issuer that is used to address unique situations in which an insured, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship and is limited to the parties to the agreement.

"Participating health care facility" means any health care facility that has a contractual relationship directly or indirectly with a health insurance issuer offering group or individual health insurance coverage setting forth the terms

and conditions on which a relevant health care service is provided to an insured, beneficiary, or enrollee under the coverage. A single case agreement between an emergency facility and an issuer that is used to address unique situations in which an insured, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

"Participating provider" means any health care provider that has a contractual relationship directly or indirectly with a health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant health care service is provided to an insured, beneficiary, or enrollee under the coverage.

"Qualifying payment amount" has the meaning given to that term in 42 U.S.C. 300gg-111(a)(3)(E) and the regulations promulgated thereunder.

"Recognized amount" means the lesser of the following amounts: (1) the amount initially billed by the provider; (2) ~~or~~ the qualifying payment amount; or, (3) if applicable, the allowable amount established by this Section.

"Stabilize" means "stabilization" as defined in Section 10 of the Managed Care Reform and Patient Rights Act.

"Treating provider" means a health care provider who has evaluated the individual.

"Visit" means, with respect to health care services

furnished to an individual at a health care facility, health care services furnished by a provider at the facility, as well as equipment, devices, telehealth services, imaging services, laboratory services, and preoperative and postoperative services regardless of whether the provider furnishing such services is at the facility.

(b) Emergency services. When a beneficiary, insured, or enrollee receives emergency services from a nonparticipating provider or a nonparticipating emergency facility, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider or a participating emergency facility. Any cost-sharing requirements shall be applied as though the emergency services had been received from a participating provider or a participating facility. Cost sharing shall be calculated based on the recognized amount for the emergency services. If the cost sharing for the same item or service furnished by a participating provider would have been a flat-dollar copayment, that amount shall be the cost-sharing amount unless the provider has billed a lesser total amount. In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the nonparticipating emergency facility for any amount beyond the cost sharing calculated in

accordance with this subsection with respect to the emergency services delivered. Administrative requirements or limitations shall be no greater than those applicable to emergency services received from a participating provider or a participating emergency facility.

(b-5) Non-emergency services at participating health care facilities.

(1) When a beneficiary, insured, or enrollee utilizes a participating health care facility and, due to any reason, covered ancillary services are provided by a nonparticipating provider during or resulting from the visit, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider for the ancillary services. Any cost-sharing requirements shall be applied as though the ancillary services had been received from a participating provider. Cost sharing shall be calculated based on the recognized amount for the ancillary services. If the cost sharing for the same item or service furnished by a participating provider would have been a flat-dollar copayment, that amount shall be the cost-sharing amount unless the provider has billed a lesser total amount. In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance

issuer, the nonparticipating provider, or the participating health care facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the ancillary services delivered. In addition to ancillary services, the requirements of this paragraph shall also apply with respect to covered items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria under paragraph (2) of this subsection.

(2) When a beneficiary, insured, or enrollee utilizes a participating health care facility and receives non-emergency covered health care services other than those described in paragraph (1) of this subsection from a nonparticipating provider during or resulting from the visit, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee incurs no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider unless the nonparticipating provider or the participating health care facility on behalf of the nonparticipating provider satisfies the notice and consent criteria provided in 42 U.S.C. 300gg-132 and regulations promulgated thereunder. If the notice and consent criteria are not satisfied, then:

(A) any cost-sharing requirements shall be applied as though the health care services had been received from a participating provider;

(B) cost sharing shall be calculated based on the recognized amount for the health care services; and

(C) in no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the participating health care facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the health care services delivered.

(c) Notwithstanding any other provision of this Code, except when the notice and consent criteria are satisfied for the situation in paragraph (2) of subsection (b-5), any benefits a beneficiary, insured, or enrollee receives for services under the situations in subsections ~~subsection~~ (b), ~~or~~ (b-5), (f), (f-5), or (f-10) are assigned to the nonparticipating providers or the facility acting on their behalf. Upon receipt of the provider's bill or facility's bill, the health insurance issuer shall provide the nonparticipating provider or the facility with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the insured, beneficiary, or enrollee. The health insurance issuer shall pay any

reimbursement subject to this Section directly to the nonparticipating provider or the facility.

(d) For bills assigned under subsection (c), the nonparticipating provider or the facility may bill the health insurance issuer for the services rendered, and the health insurance issuer may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating provider or the facility. Within 30 calendar days after the provider or facility transmits the bill to the health insurance issuer, the issuer shall send an initial payment or notice of denial of payment with the written explanation of benefits to the provider or facility. If attempts to negotiate reimbursement for services provided by a nonparticipating provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the health insurance issuer, then the health insurance issuer or nonparticipating provider or the facility may initiate binding arbitration to determine payment for services provided on a per-bill or batched-bill basis, in accordance with Section 300gg-111 of the Public Health Service Act and the regulations promulgated thereunder. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the

Department of Insurance.

(e) The Department of Insurance shall publish a list of approved arbitrators or entities that shall provide binding arbitration. These arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree on an arbitrator from the Department of Insurance's or its approved entity's list of arbitrators. If no agreement can be reached, then a list of 5 arbitrators shall be provided by the Department of Insurance or the approved entity. From the list of 5 arbitrators, the health insurance issuer can veto 2 arbitrators and the provider or facility can veto 2 arbitrators. The remaining arbitrator shall be the chosen arbitrator. This arbitration shall consist of a review of the written submissions by both parties. The arbitrator shall not establish a rebuttable presumption that the qualifying payment amount should be the total amount owed to the provider or facility by the combination of the issuer and the insured, beneficiary, or enrollee. Binding arbitration shall provide for a written decision within 45 days after the request is filed with the Department of Insurance. Both parties shall be bound by the arbitrator's decision. The arbitrator's expenses and fees, together with other expenses, not including attorney's fees, incurred in the conduct of the arbitration, shall be paid as provided in the decision.

(f) <u>(f) Payments to nonparticipating ground ambulance</u>

service providers. ~~(Blank).~~

(1) On or after July 1, 2025, notwithstanding any other provision of this Section, when a beneficiary, insured, or enrollee receives services from a nonparticipating ground ambulance service provider, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating ground ambulance service provider. Any cost-sharing requirements shall be applied as though the services provided by the nonparticipating ground ambulance service provider had been provided by a participating ground ambulance service provider. The health insurance issuer shall approve charges for nonparticipating ground ambulance service providers at a recognized amount that shall be calculated as the lessor of: (i) the nonparticipating ground ambulance service provider's billed charge; (ii) the negotiated rate between the nonparticipating ground ambulance service provider and the health insurance insurer; or (iii) the maximum allowable amount specified in subsection (f-5) or the amount specified in subsection (f-10).

(2) Payment for ground ambulance services shall be made on a per occurrence basis. For purposes of this subsection, occurrence means in individual ground

ambulance response and, if applicable, the corresponding transport and shall consist of a base charge and, if applicable, a loaded mileage charge.

(4) The cost sharing amount for any occurrence in which a ground ambulance service is provided to a beneficiary, insured, or enrollee, shall not exceed the lessor of the plan's emergency room visit copay or 10% of the recognized amount for the occurrence.

(5) With respect appeals for payments made by health insurance issuers under this subsection, beneficiaries, insureds, enrollees, and ground ambulance service providers are not required to follow a health insurance issuer's internal appeals process and may seek relief in any appropriate court for the purpose of resolving a payment dispute. In such a dispute litigated in court, a prevailing beneficiary, insured, enrollee, or ground ambulance service provider shall be entitled to payment for reasonable attorney's fees and may seek payment for other damages, including punitive damages, arising from a health insurance issuer's failure to provide payment in compliance with this Act.

(6) Definition of emergency. In addition to any other criteria for the definition of emergency described in this Act or in the definition of emergency described in the Healthcare Common Procedure Coding System (HCPCS) as it pertains to ground ambulance services, ground ambulance

services provided by ground ambulance service providers shall be considered emergency services if the services were provided pursuant to a request to 9-1-1 or an equivalent telephone number, texting system, or other method of summonsing emergency services or if the services provided were provided when a patient's condition, at the time of service, was considered to be an emergency medical condition as defined by this Act or as determined by a physician licensed pursuant to the Medical Practice Act of 1997.

(7) As used in subsections (f-5) and (f-10):

(i) "Evaluation" means the provision of a medical screening examination to determine whether an emergency medical condition exists.

(ii) "Treatment" means the provision of an assessment and a therapy or therapeutic agent used to treat a medical condition, or a procedure used to treat a medical condition.

(iii) "Paramedic intercept" means a situation when a paramedic (advanced life support) staffed ambulance rendezvous with a non-paramedic (basic life support or intermediate life support) staffed ambulance to provide advanced life support care. Advanced life support is warranted when a patient's condition and need for treatment exceeds the basic life support or intermediate life

support level of care.

(iv) "Unit of government" means a county, as described in the Counties Code; a township, as described in the Township Code; a municipality, as described in the Municipal Code; a fire protection district, as described in the Fire Protection District Act; a rescue squad district, as described in the Rescue Squad District Act; or an Emergency Services District, as described in the Emergency Services District Act.

(f-5) The maximum allowable payment amounts by individual service types for nonparticipating ground ambulance service providers owned, operated, or controlled by a private organization, to include both private for profit organizations and private not-for-profit organizations and nonparticipating ground ambulance service providers owned, operated, or controlled by a unit of government that does not participate in the Ground Emergency Medical Transportation (GEMT) program administered by the Department of Healthcare and Family Services, shall be as follows: (i) basic life support, non-emergency base $2,030; (ii) basic life support, emergency base $2,660; (iii) advanced life support, non-emergency, level 1 base $2,800; (iv) advanced life support, emergency, level 1 base $2,905; (v) advanced life support, level 2 base $3,080; (vi) specialty care transport base $7,140; (vii) evaluation without transport, 25% of the basic life support, emergency

base; (vii) treatment without transport, 50% of the advanced life support, emergency, level 1 base; (viii) paramedic intercept, 75% of the advanced life support, emergency, level 1 base; and (ix) ground mileage, per loaded mile $56. The amounts in this subsection shall be adjusted at a rate of 5% annually, effective on January 1 of each year, beginning on January 1, 2026.

(f-10) Payments to nonparticipating ground ambulance service providers owned, operated, or controlled by a unit of government that participates in the Ground Emergency Medical Transportation (GEMT) program administered by the Department of Healthcare and Family Services, shall be the cost-based amount, as reflected in the ground ambulance service provider's GEMT cost report for the applicable date of service. Individual services types shall be as follows: (i) basic life support, emergency base; (ii) advanced life support, emergency, level 1 base; (iii) advanced life support, level 2 base; (iv) evaluation without transport, 100% of the basic life support, emergency base, no mileage; (v) treatment without transport, 100% of the advanced life support, emergency, level 1 base, no mileage; (vi) paramedic intercept, 100% of the advanced life support, emergency, level 1 base, no mileage; and (vii) ground mileage, per loaded mile. In situations where a ground ambulance service provider that qualifies for payments under this subsection charges for a services type, including a basic life support, non-emergency

base, or an advanced life support, non-emergency base payments by the health insurance issuers shall be as described in subsection (f-5).

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d). Upon the issuance of the arbitrator's decision, Section 368a applies with respect to the amount, if any, by which the arbitrator's determination exceeds the issuer's initial payment under subsection (c), or the entire amount of the arbitrator's determination if initial payment was denied. Any interest required to be paid to a provider under Section 368a shall not accrue until after 30 days of an arbitrator's decision as provided in subsection (d), but in no circumstances longer than 150 days from the date the nonparticipating facility-based provider billed for services rendered.

(h) Nothing in this Section shall be interpreted to change the prudent layperson provisions with respect to emergency services under the Managed Care Reform and Patient Rights Act.

(i) Nothing in this Section shall preclude a health care provider from billing a beneficiary, insured, or enrollee for reasonable administrative fees, such as service fees for checks returned for nonsufficient funds and missed appointments.

(j) Nothing in this Section shall preclude a beneficiary, insured, or enrollee from assigning benefits to a nonparticipating provider when the notice and consent criteria

are satisfied under paragraph (2) of subsection (b-5) or in any other situation not described in subsection (b) or (b-5).

(k) Except when the notice and consent criteria are satisfied under paragraph (2) of subsection (b-5), if an individual receives health care services under the situations described in subsection (b) or (b-5), no referral requirement or any other provision contained in the policy or certificate of coverage shall deny coverage, reduce benefits, or otherwise defeat the requirements of this Section for services that would have been covered with a participating provider. However, this subsection shall not be construed to preclude a provider contract with a health insurance issuer, or with an administrator or similar entity acting on the issuer's behalf, from imposing requirements on the participating provider, participating emergency facility, or participating health care facility relating to the referral of covered individuals to nonparticipating providers.

(l) Except if the notice and consent criteria are satisfied under paragraph (2) of subsection (b-5), cost-sharing amounts calculated in conformity with this Section shall count toward any deductible or out-of-pocket maximum applicable to in-network coverage.

(m) The Department has the authority to enforce the requirements of this Section in the situations described in subsections (b) and (b-5), and in any other situation for which 42 U.S.C. Chapter 6A, Subchapter XXV, Parts D or E and

regulations promulgated thereunder would prohibit an individual from being billed or liable for emergency services furnished by a nonparticipating provider or nonparticipating emergency facility or for non-emergency health care services furnished by a nonparticipating provider at a participating health care facility.

(m-5) A failure by a health insurance issuer to comply with the requirements in this Section constitutes an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act. All remedies, penalties, and authority granted to the Attorney General by that Act shall be available to the Attorney General for the enforcement of this Section.

(n) This Section does not apply with respect to air ambulance ~~or ground ambulance~~ services. This Section does not apply to any policy of excepted benefits or to short-term, limited-duration health insurance coverage.

(Source: P.A. 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-440, eff. 1-1-24.)

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

Sec. 370g. Definitions. As used in this Article, the following definitions apply:

(a) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental,

vision, ground ambulance services, and pharmaceutical services or products.

(b) "Insurer" means an insurance company or a health service corporation authorized in this State to issue policies or subscriber contracts which reimburse for expenses of health care services.

(c) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(d) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

(e) "Noninstitutional provider" means any person licensed under the Medical Practice Act of 1987, as now or hereafter amended.

(f) "Beneficiary" means an individual entitled to reimbursement for expenses of or the discount of provider fees for health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator.

(g) "Administrator" means any person, partnership or corporation, other than an insurer or health maintenance organization holding a certificate of authority under the "Health Maintenance Organization Act", as now or hereafter amended, that arranges, contracts with, or administers

contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

(h) "Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 102-409, eff. 1-1-22.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 4-15 as follows:

(215 ILCS 125/4-15) (from Ch. 111 1/2, par. 1409.8)

Sec. 4-15. (a) No contract or evidence of coverage for basic health care services delivered, issued for delivery, renewed or amended by a Health Maintenance Organization shall exclude coverage for emergency transportation by ambulance. For the purposes of this Section, the term "emergency" means a need for immediate medical attention resulting from a life threatening condition or situation or a need for immediate medical attention as otherwise reasonably determined by a physician, public safety official or other emergency medical personnel.

(b) Payments to nonparticipating ground ambulance service providers shall be as described in subsections (f), (f-5), and (f-10) of Section 356z.3a of the Illinois Insurance Code. ~~Upon reasonable demand by a provider of emergency transportation by ambulance, a Health Maintenance Organization shall promptly~~

~~pay to the provider, subject to coverage limitations stated in the contract or evidence of coverage, the charges for emergency transportation by ambulance provided to an enrollee in a health care plan arranged for by the Health Maintenance Organization. By accepting any such payment from the Health Maintenance Organization, the provider of emergency transportation by ambulance agrees not to seek any payment from the enrollee for services provided to the enrollee.~~

(Source: P.A. 86-833; 86-1028.)

Section 15. The Consumer Fraud and Deceptive Business Practices Act is amended by adding Section 2HHHH as follows:

(815 ILCS 505/2HHHH new)

Sec. 2HHHH. Violations of the Consumer Protection from Surprise Health Care Billing Act. A health insurer commits an unlawful practice within the meaning of this Act when it refuses to comply with the requirements of subsection (m-5) of Section 356z.3a of the Illinois Insurance Code.

Section 99. Effective date. This Act takes effect July 1, 2025.