



Sen. Ram Villivalam

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10400SB2405sam001

LRB104 10637 BAB 25121 a

1 AMENDMENT TO SENATE BILL 2405

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 2405 by replacing  
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by  
5 changing Sections 356z.3a as follows:

6 (215 ILCS 5/356z.3a)

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

9 (a) As used in this Section:

10 "Ancillary services" means:

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

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

16 (3) diagnostic services, including radiology and

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

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

9 (5) items and services provided by a nonparticipating  
10 provider if there is no participating provider who can  
11 furnish the item or service at the facility; and

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

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

25 "Emergency department of a hospital" means any hospital  
26 department that provides emergency services, including a

1 hospital outpatient department.

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

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

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

10 (1) in general, an emergency medical screening  
11 examination, including ancillary services routinely  
12 available to the emergency department to evaluate such  
13 emergency medical condition, and such further medical  
14 examination and treatment as would be required to  
15 stabilize the patient regardless of the department of the  
16 hospital or other facility in which such further  
17 examination or treatment is furnished; or

18 (2) additional items and services for which benefits  
19 are provided or covered under the coverage and that are  
20 furnished by a nonparticipating provider or  
21 nonparticipating emergency facility regardless of the  
22 department of the hospital or other facility in which such  
23 items are furnished after the insured, beneficiary, or  
24 enrollee is stabilized and as part of outpatient  
25 observation or an inpatient or outpatient stay with  
26 respect to the visit in which the services described in

1 paragraph (1) are furnished. Services after stabilization  
2 cease to be emergency services only when all the  
3 conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and  
4 regulations thereunder are met.

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

8 "Ground ambulance service" means both medical  
9 transportation services that are described as ground ambulance  
10 services by the Centers for Medicare and Medicaid Services and  
11 medical non-transportation services such as evaluation without  
12 transport, treatment without transport, or paramedic intercept  
13 that are either provided in a vehicle that is licensed as an  
14 ambulance under the Emergency Medical Services (EMS) Systems  
15 Act or provided by EMS Personnel assigned to a vehicle that is  
16 licensed as an ambulance under the Emergency Medical Services  
17 (EMS) Systems Act.

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

26 "Health care facility" means, in the context of

1 non-emergency services, any of the following:

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

3 (2) a hospital outpatient department;

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

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

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

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

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

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

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

26 (1) an emergency department of a hospital;

1 (2) a Freestanding Emergency Center;

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

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

7 "Nonparticipating provider" means, with respect to the  
8 furnishing of an item or service under a policy of group or  
9 individual health insurance coverage, any health care provider  
10 who does not have a contractual relationship directly or  
11 indirectly with a health insurance issuer in relation to the  
12 coverage.

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

20 (1) an emergency department of a hospital;

21 (2) a Freestanding Emergency Center;

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

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

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

7           "Participating health care facility" means any health care  
8 facility that has a contractual relationship directly or  
9 indirectly with a health insurance issuer offering group or  
10 individual health insurance coverage setting forth the terms  
11 and conditions on which a relevant health care service is  
12 provided to an insured, beneficiary, or enrollee under the  
13 coverage. A single case agreement between an emergency  
14 facility and an issuer that is used to address unique  
15 situations in which an insured, beneficiary, or enrollee  
16 requires services that typically occur out-of-network  
17 constitutes a contractual relationship for purposes of this  
18 definition and is limited to the parties to the agreement.

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

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

1 promulgated thereunder.

2 "Recognized amount" means the lesser of the amount  
3 initially billed by the provider or the qualifying payment  
4 amount.

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

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

9 "Visit" means, with respect to health care services  
10 furnished to an individual at a health care facility, health  
11 care services furnished by a provider at the facility, as well  
12 as equipment, devices, telehealth services, imaging services,  
13 laboratory services, and preoperative and postoperative  
14 services regardless of whether the provider furnishing such  
15 services is at the facility.

16 (b) Emergency services. When a beneficiary, insured, or  
17 enrollee receives emergency services from a nonparticipating  
18 provider or a nonparticipating emergency facility, the health  
19 insurance issuer shall ensure that the beneficiary, insured,  
20 or enrollee shall incur no greater out-of-pocket costs than  
21 the beneficiary, insured, or enrollee would have incurred with  
22 a participating provider or a participating emergency  
23 facility. Any cost-sharing requirements shall be applied as  
24 though the emergency services had been received from a  
25 participating provider or a participating facility. Cost  
26 sharing shall be calculated based on the recognized amount for

1 the emergency services. If the cost sharing for the same item  
2 or service furnished by a participating provider would have  
3 been a flat-dollar copayment, that amount shall be the  
4 cost-sharing amount unless the provider has billed a lesser  
5 total amount. In no event shall the beneficiary, insured,  
6 enrollee, or any group policyholder or plan sponsor be liable  
7 to or billed by the health insurance issuer, the  
8 nonparticipating provider, or the nonparticipating emergency  
9 facility for any amount beyond the cost sharing calculated in  
10 accordance with this subsection with respect to the emergency  
11 services delivered. Administrative requirements or limitations  
12 shall be no greater than those applicable to emergency  
13 services received from a participating provider or a  
14 participating emergency facility.

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

17 (1) When a beneficiary, insured, or enrollee utilizes  
18 a participating health care facility and, due to any  
19 reason, covered ancillary services are provided by a  
20 nonparticipating provider during or resulting from the  
21 visit, the health insurance issuer shall ensure that the  
22 beneficiary, insured, or enrollee shall incur no greater  
23 out-of-pocket costs than the beneficiary, insured, or  
24 enrollee would have incurred with a participating provider  
25 for the ancillary services. Any cost-sharing requirements  
26 shall be applied as though the ancillary services had been

1 received from a participating provider. Cost sharing shall  
2 be calculated based on the recognized amount for the  
3 ancillary services. If the cost sharing for the same item  
4 or service furnished by a participating provider would  
5 have been a flat-dollar copayment, that amount shall be  
6 the cost-sharing amount unless the provider has billed a  
7 lesser total amount. In no event shall the beneficiary,  
8 insured, enrollee, or any group policyholder or plan  
9 sponsor be liable to or billed by the health insurance  
10 issuer, the nonparticipating provider, or the  
11 participating health care facility for any amount beyond  
12 the cost sharing calculated in accordance with this  
13 subsection with respect to the ancillary services  
14 delivered. In addition to ancillary services, the  
15 requirements of this paragraph shall also apply with  
16 respect to covered items or services furnished as a result  
17 of unforeseen, urgent medical needs that arise at the time  
18 an item or service is furnished, regardless of whether the  
19 nonparticipating provider satisfied the notice and consent  
20 criteria under paragraph (2) of this subsection.

21 (2) When a beneficiary, insured, or enrollee utilizes  
22 a participating health care facility and receives  
23 non-emergency covered health care services other than  
24 those described in paragraph (1) of this subsection from a  
25 nonparticipating provider during or resulting from the  
26 visit, the health insurance issuer shall ensure that the

1 beneficiary, insured, or enrollee incurs no greater  
2 out-of-pocket costs than the beneficiary, insured, or  
3 enrollee would have incurred with a participating provider  
4 unless the nonparticipating provider or the participating  
5 health care facility on behalf of the nonparticipating  
6 provider satisfies the notice and consent criteria  
7 provided in 42 U.S.C. 300gg-132 and regulations  
8 promulgated thereunder. If the notice and consent criteria  
9 are not satisfied, then:

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

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

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

22 (b-10) Coverage for out-of-network emergency ground  
23 ambulance services and urgent ground ambulance services. Any  
24 group or individual policy of accident and health insurance  
25 amended, delivered, issued, or renewed on or after January 1,  
26 2027 shall provide coverage for both emergency ground

1 ambulance services and urgent ground ambulance services. Upon  
2 reasonable demand by a provider of emergency ground ambulance  
3 services or urgent ground ambulance services, a health  
4 insurance issuer shall promptly approve the full amount of the  
5 charges for services provided to the beneficiary, insured, or  
6 enrollee and pay directly to the provider any portion of the  
7 charges for services provided to a beneficiary, insured, or  
8 enrollee that the health insurance issuer is, by contract,  
9 responsible for paying. By accepting the payment from the  
10 health insurance issuer, the provider of emergency ground  
11 ambulance services or urgent ground ambulance services agrees  
12 not to seek any payment from the beneficiary, insured, or  
13 enrollee for any amount which exceeds the deductible,  
14 coinsurance, or copay for services provided to the  
15 beneficiary, insured, or enrollee.

16 As used in this subsection:

17 "Emergency ground ambulance service" means ground  
18 ambulance service that is needed for immediate medical  
19 attention resulting from a life-threatening condition or  
20 situation or as otherwise reasonably determined by a  
21 physician, public safety official, or other emergency medical  
22 personnel.

23 "Urgent ground ambulance service" means ground ambulance  
24 service that is deemed medically necessary by a health care  
25 professional and is required within 12 hours after the  
26 certification of the need for such service.

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

16           (d) For bills assigned under subsection (c), the  
17 nonparticipating provider or the facility may bill the health  
18 insurance issuer for the services rendered, and the health  
19 insurance issuer may pay the billed amount or attempt to  
20 negotiate reimbursement with the nonparticipating provider or  
21 the facility. Within 30 calendar days after the provider or  
22 facility transmits the bill to the health insurance issuer,  
23 the issuer shall send an initial payment or notice of denial of  
24 payment with the written explanation of benefits to the  
25 provider or facility. If attempts to negotiate reimbursement  
26 for services provided by a nonparticipating provider do not

1 result in a resolution of the payment dispute within 30 days  
2 after receipt of written explanation of benefits by the health  
3 insurance issuer, then the health insurance issuer or  
4 nonparticipating provider or the facility may initiate binding  
5 arbitration to determine payment for services provided on a  
6 per-bill or batched-bill basis, in accordance with Section  
7 300gg-111 of the Public Health Service Act and the regulations  
8 promulgated thereunder. The party requesting arbitration shall  
9 notify the other party arbitration has been initiated and  
10 state its final offer before arbitration. In response to this  
11 notice, the nonrequesting party shall inform the requesting  
12 party of its final offer before the arbitration occurs.  
13 Arbitration shall be initiated by filing a request with the  
14 Department of Insurance.

15 (e) The Department of Insurance shall publish a list of  
16 approved arbitrators or entities that shall provide binding  
17 arbitration. These arbitrators shall be American Arbitration  
18 Association or American Health Lawyers Association trained  
19 arbitrators. Both parties must agree on an arbitrator from the  
20 Department of Insurance's or its approved entity's list of  
21 arbitrators. If no agreement can be reached, then a list of 5  
22 arbitrators shall be provided by the Department of Insurance  
23 or the approved entity. From the list of 5 arbitrators, the  
24 health insurance issuer can veto 2 arbitrators and the  
25 provider or facility can veto 2 arbitrators. The remaining  
26 arbitrator shall be the chosen arbitrator. This arbitration

1 shall consist of a review of the written submissions by both  
2 parties. The arbitrator shall not establish a rebuttable  
3 presumption that the qualifying payment amount should be the  
4 total amount owed to the provider or facility by the  
5 combination of the issuer and the insured, beneficiary, or  
6 enrollee. Binding arbitration shall provide for a written  
7 decision within 45 days after the request is filed with the  
8 Department of Insurance. Both parties shall be bound by the  
9 arbitrator's decision. The arbitrator's expenses and fees,  
10 together with other expenses, not including attorney's fees,  
11 incurred in the conduct of the arbitration, shall be paid as  
12 provided in the decision.

13 (f) (Blank).

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

26 (h) Nothing in this Section shall be interpreted to change

1 the prudent layperson provisions with respect to emergency  
2 services under the Managed Care Reform and Patient Rights Act.

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

8 (j) Nothing in this Section shall preclude a beneficiary,  
9 insured, or enrollee from assigning benefits to a  
10 nonparticipating provider when the notice and consent criteria  
11 are satisfied under paragraph (2) of subsection (b-5) or in  
12 any other situation not described in subsection (b) or (b-5).

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

1 nonparticipating providers.

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

7 (m) The Department has the authority to enforce the  
8 requirements of this Section in the situations described in  
9 subsections (b) and (b-5), and in any other situation for  
10 which 42 U.S.C. Chapter 6A, Subchapter XXV, Parts D or E and  
11 regulations promulgated thereunder would prohibit an  
12 individual from being billed or liable for emergency services  
13 furnished by a nonparticipating provider or nonparticipating  
14 emergency facility or for non-emergency health care services  
15 furnished by a nonparticipating provider at a participating  
16 health care facility.

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

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

23 Section 99. Effective date. This Act takes effect January  
24 1, 2027."