SB3288

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB3288

Introduced 2/3/2026, by Sen. Ram Villivalam

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a

Amends the Illinois Insurance Code. Provides that the reimbursement rate a health insurance issuer must pay to nonparticipating ground ambulance service providers subject to a unit of local government is equal to the rate established or approved by the governing body of the local government providing ground ambulance service (instead of the local government having jurisdiction for that area or subarea).

LRB104 16103 BAB 29407 b

A BILL FOR

1 AN ACT concerning regulation.

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

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

6 (215 ILCS 5/356z.3a)
7 (Text of Section before amendment by P.A. 104-60)
8 Sec. 356z.3a. Billing; emergency services;
9 nonparticipating providers.
10 (a) As used in this Section:
11 "Ancillary services" means:
12 (1) items and services related to emergency medicine,
13 anesthesiology, pathology, radiology, and neonatology that
14 are provided by any health care provider;
15 (2) items and services provided by assistant surgeons,
16 hospitalists, and intensivists;
17 (3) diagnostic services, including radiology and
18 laboratory services, except for advanced diagnostic
19 laboratory tests identified on the most current list
20 published by the United States Secretary of Health and
21 Human Services under 42 U.S.C. 300gg-132(b)(3);
22 (4) items and services provided by other specialty
23 practitioners as the United States Secretary of Health and

1 Human Services specifies through rulemaking under 42
2 U.S.C. 300gg-132(b)(3);
3 (5) items and services provided by a nonparticipating
4 provider if there is no participating provider who can
5 furnish the item or service at the facility; and
6 (6) items and services provided by a nonparticipating
7 provider if there is no participating provider who will
8 furnish the item or service because a participating
9 provider has asserted the participating provider's rights
10 under the Health Care Right of Conscience Act.
11 "Average gross charge rate" means, with respect to
12 nonparticipating ground ambulance service providers, the
13 average of the provider's gross charge rates in place for each
14 individual charge described in subsection (b-15) of this
15 Section for dates of service that fall within the 12-month
16 period ending on June 30 immediately preceding the date on
17 which the reporting of average gross charge rates is required.
18 "Cost sharing" means the amount an insured, beneficiary,
19 or enrollee is responsible for paying for a covered item or
20 service under the terms of the policy or certificate. "Cost
21 sharing" includes copayments, coinsurance, and amounts paid
22 toward deductibles, but does not include amounts paid towards
23 premiums, balance billing by out-of-network providers, or the
24 cost of items or services that are not covered under the policy
25 or certificate.
26 "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

1 respect to the visit in which the services described in
2 paragraph (1) are furnished. Services after stabilization
3 cease to be emergency services only when all the
4 conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and
5 regulations thereunder are met.
6 "Emergency ground ambulance service" means ground
7 ambulance service provided by ground ambulance service
8 providers, regardless of whether the patient was transported,
9 if the service was provided pursuant to a request to 9-1-1 or
10 an equivalent telephone number, texting system, or other
11 method of summoning emergency service or if the service
12 provided was provided when a patient's condition, at the time
13 of service, was considered to be an emergency medical
14 condition as determined by a physician licensed under the
15 Medical Practice Act of 1987.
16 "Evaluation" means, with respect to emergency ground
17 ambulance service, the provision of a medical screening
18 examination to determine whether an emergency medical
19 condition exists.
20 "Freestanding Emergency Center" means a facility licensed
21 under Section 32.5 of the Emergency Medical Services (EMS)
22 Systems Act.
23 "Ground ambulance service" means both medical
24 transportation service that is described as ground ambulance
25 service by the Centers for Medicare and Medicaid Services and
26 medical nontransportation service, such as evaluation without

1 transport, treatment without transport, or paramedic
2 intercept, and that is, in either case, provided in a vehicle
3 that is licensed as an ambulance under the Emergency Medical
4 Services (EMS) Systems Act or by EMS Personnel assigned to a
5 vehicle that is licensed as an ambulance under the Emergency
6 Medical Services (EMS) Systems Act. "Ground ambulance service"
7 may include any combination of the following: emergency ground
8 ambulance service in a ground ambulance, urgent ground
9 ambulance service, evaluation without treatment, treatment
10 without transport, and paramedic intercept.

11 "Ground ambulance service provider" means a vehicle
12 service provider under the Emergency Medical Services (EMS)
13 Systems Act that operates licensed ground ambulances for the
14 purpose of providing emergency ground ambulance services,
15 urgent ground ambulances services, or both. "Ground ambulance
16 service provider" includes both ambulance providers and
17 ambulance suppliers as described by the Centers for Medicare
18 and Medicaid Services.

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

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

22 (2) a hospital outpatient department;

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

25 (4) an ambulatory surgical treatment center as defined
26 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 ground ambulance service provider"

means, with respect to the furnishing of an item or services under a policy of group or individual health insurance coverage, any ground ambulance service provider that does not have a contractual relationship directly or indirectly with a health insurance issuer in relation to the coverage.

"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.

"Paramedic intercept" means a service in which a ground ambulance staffed by licensed paramedics rendezvouses with a ground ambulance staffed with nonparamedics to provide advanced life support care. As used in this definition, "advanced life support care" means life support care that is warranted when a patient's condition and need for treatment exceed the basic life support or intermediate life support level of care.

"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 ground ambulance service provider" means any ground ambulance service 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. As used in this definition, a single case agreement between a ground ambulance service provider and a health insurance 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 of the agreement.

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

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

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

22 "Recognized amount" means, except as otherwise provided in
23 this Section, the lesser of the amount initially billed by the
24 provider or the qualifying payment amount.

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

1 "Treating provider" means a health care provider who has
2 evaluated the individual.
3 "Treatment" means, with respect to the provision of
4 emergency ground ambulance service, the provision of an
5 evaluation and either (i) a therapy or therapeutic agent used
6 to treat an emergency medical condition or (ii) a procedure
7 used to treat an emergency medical condition.
8 "Urgent ground ambulance service" means ground ambulance
9 service that is deemed medically necessary by a health care
10 professional and is required within 12 hours after the
11 certification of the need for the service.
12 "Visit" means, with respect to health care services
13 furnished to an individual at a health care facility, health
14 care services furnished by a provider at the facility, as well
15 as equipment, devices, telehealth services, imaging services,
16 laboratory services, and preoperative and postoperative
17 services regardless of whether the provider furnishing such
18 services is at the facility.
19 (b) Emergency services. When a beneficiary, insured, or
20 enrollee receives emergency services from a nonparticipating
21 provider or a nonparticipating emergency facility, the health
22 insurance issuer shall ensure that the beneficiary, insured,
23 or enrollee shall incur no greater out-of-pocket costs than
24 the beneficiary, insured, or enrollee would have incurred with
25 a participating provider or a participating emergency
26 facility. Any cost-sharing requirements shall be applied as

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

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

20 (1) When a beneficiary, insured, or enrollee utilizes
21 a participating health care facility and, due to any
22 reason, covered ancillary services are provided by a
23 nonparticipating provider during or resulting from the
24 visit, the health insurance issuer shall ensure that the
25 beneficiary, insured, or enrollee shall incur no greater
26 out-of-pocket costs than the beneficiary, insured, or

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

24 (2) When a beneficiary, insured, or enrollee utilizes
25 a participating health care facility and receives
26 non-emergency covered health care services other than

1 those described in paragraph (1) of this subsection from a
2 nonparticipating provider during or resulting from the
3 visit, the health insurance issuer shall ensure that the
4 beneficiary, insured, or enrollee incurs no greater
5 out-of-pocket costs than the beneficiary, insured, or
6 enrollee would have incurred with a participating provider
7 unless the nonparticipating provider or the participating
8 health care facility on behalf of the nonparticipating
9 provider satisfies the notice and consent criteria
10 provided in 42 U.S.C. 300gg-132 and regulations
11 promulgated thereunder. If the notice and consent criteria
12 are not satisfied, then:
13 (A) any cost-sharing requirements shall be applied
14 as though the health care services had been received
15 from a participating provider;
16 (B) cost sharing shall be calculated based on the
17 recognized amount for the health care services; and
18 (C) in no event shall the beneficiary, insured,
19 enrollee, or any group policyholder or plan sponsor be
20 liable to or billed by the health insurance issuer,
21 the nonparticipating provider, or the participating
22 health care facility for any amount beyond the cost
23 sharing calculated in accordance with this subsection
24 with respect to the health care services delivered.
25 (b-10) Coverage for ground ambulance services provided by
26 nonparticipating ground ambulance service providers.

1 (1) Any group or individual policy of accident and
2 health insurance amended, delivered, issued, or renewed on
3 or after January 1, 2027 shall provide coverage for both
4 emergency ground ambulance service and urgent ground
5 ambulance service.
6 (2) Beginning on January 1, 2027, when a beneficiary,
7 insured, or enrollee receives emergency ground ambulance
8 services or urgent ambulance services from a
9 nonparticipating ground ambulance service provider, the
10 health insurance issuer shall ensure that the beneficiary,
11 insured, or enrollee shall incur no greater out-of-pocket
12 costs than the beneficiary, insured, or enrollee would
13 have incurred with a participating ground ambulance
14 provider. Any cost-sharing requirements shall be applied
15 as though the emergency ground ambulance services or
16 urgent ground ambulance services had been received from a
17 participating ground ambulance service provider. Except as
18 otherwise provided in State or federal law, cost sharing
19 shall be calculated based on the lesser of the policy's
20 copayment or coinsurance for an emergency room visit or
21 10% of the recognized amount. For purposes of this
22 subsection, the recognized amount shall be calculated as
23 provided for in paragraph (3) of this subsection. Except
24 as otherwise provided for in State or federal law, if the
25 cost sharing for the same item or service furnished by a
26 participating ground ambulance provider would have been a

flat-dollar copayment, that amount shall be the cost-sharing amount unless the nonparticipating ground ambulance provider has billed a lesser total amount.

(3) Upon reasonable demand by a nonparticipating ground ambulance service provider and after subtracting the beneficiary's, insured's, or enrollee's cost sharing amount, a health insurance issuer shall pay the nonparticipating ground ambulance service provider as follows:

(A) for nonparticipating ground ambulance service providers subject to a unit of local government ~~that has jurisdiction over where the service was provided~~, a rate that is equal to the rate established or approved by the governing body of the local government providing ground ambulance service ~~having jurisdiction for that area or subarea~~; or

(B) for nonparticipating ground ambulance service providers that are not subject to the jurisdiction of a unit of local government, a rate that is equal to the lesser of (i) the negotiated rate between the nonparticipating ground ambulance service provider and the health insurance issuer; (ii) 85% of the nonparticipating ground ambulance service provider's billed charges; or (iii) the average gross charge rate in effect for the date of service in question for a base charge and, if applicable, a loaded mileage

1 charge, the nonparticipating ground ambulance service
2 provider has filed with the Department of Public
3 Health in accordance with subsection (b-15).

4 By accepting the payment from the health insurance
5 issuer, the nonparticipating ground ambulance service
6 provider shall not seek any payment from the
7 beneficiary, insured, or enrollee for any amount that
8 exceeds the deductible, coinsurance, or copay for
9 services provided to the beneficiary, insured, or
10 enrollee.

11 (b-15) Beginning on October 1, 2026, and each October 1
12 thereafter, each nonparticipating ground ambulance service
13 provider shall file annually with the Department of Public
14 Health, in the form and manner prescribed by the Department of
15 Public Health, its average gross charge rates and any other
16 information required by the Department of Public Health, by
17 rule, for each of the following ground ambulance charge
18 descriptions, as applicable: (1) basic life support, urgent
19 base; (2) basic life support, emergency base; (3) advanced
20 life support, urgent, level 1 base; (4) advanced life support,
21 emergency, level 1 base; (5) advanced life support, emergency,
22 level 2 base; (6) specialty care transport base; (7) emergency
23 response, evaluation without transport base; (8) emergency
24 response, treatment without transport base; (9) emergency
25 response, paramedic intercept base; and (10) loaded mileage,
26 per loaded mile charge for each of the applicable base charge

1 descriptions services. The Department of Public Health shall
2 publish the submitted rate information by January 1, 2027 and
3 every January 1 thereafter. The Department of Public Health
4 may request information from ground ambulance service
5 providers and health insurance issuers regarding factors
6 contributing to the network status of the ground ambulance
7 service providers. The Department of Public Health may, upon
8 the submission of rate information, assess a fee to each
9 ground ambulance service provider that shall not exceed the
10 administrative costs to complete the Department of Public
11 Health's obligations in this subsection. The Department of
12 Public Health may also request information from nationally
13 recognized organizations that provide data on health care
14 costs. The Department of Insurance shall direct the health
15 insurance issuer to the location in which the information
16 reported to the Department of Public Health is stored.
17 (c) Notwithstanding any other provision of this Code,
18 except when the notice and consent criteria are satisfied for
19 the situation in paragraph (2) of subsection (b-5), any
20 benefits a beneficiary, insured, or enrollee receives for
21 services under the situations in subsection (b), (b-5),
22 (b-10), or (b-15) are assigned to the nonparticipating
23 providers, nonparticipating ground ambulance service provider,
24 or the facility acting on their behalf. Upon receipt of the
25 provider's bill or facility's bill, the health insurance
26 issuer shall provide the nonparticipating provider,

1 nonparticipating ground ambulance service provider, or the
2 facility with a written explanation of benefits that specifies
3 the proposed reimbursement and the applicable deductible,
4 copayment, or coinsurance amounts owed by the insured,
5 beneficiary, or enrollee. The health insurance issuer shall
6 pay any reimbursement subject to this Section directly to the
7 nonparticipating provider, nonparticipating ground ambulance
8 service provider, or the facility.

9 (d) For bills assigned under subsection (c), the
10 nonparticipating provider or the facility may bill the health
11 insurance issuer for the services rendered, and the health
12 insurance issuer may pay the billed amount or attempt to
13 negotiate reimbursement with the nonparticipating provider or
14 the facility. Within 30 calendar days after the provider or
15 facility transmits the bill to the health insurance issuer,
16 the issuer shall send an initial payment or notice of denial of
17 payment with the written explanation of benefits to the
18 provider or facility. If attempts to negotiate reimbursement
19 for services provided by a nonparticipating provider do not
20 result in a resolution of the payment dispute within 30 days
21 after receipt of written explanation of benefits by the health
22 insurance issuer, then the health insurance issuer or
23 nonparticipating provider or the facility may initiate binding
24 arbitration to determine payment for services provided on a
25 per-bill or batched-bill basis, in accordance with Section
26 300gg-111 of the Public Health Service Act and the regulations

1 promulgated thereunder. The party requesting arbitration shall
2 notify the other party arbitration has been initiated and
3 state its final offer before arbitration. In response to this
4 notice, the nonrequesting party shall inform the requesting
5 party of its final offer before the arbitration occurs.
6 Arbitration shall be initiated by filing a request with the
7 Department of Insurance.

8 (e) The Department of Insurance shall publish a list of
9 approved arbitrators or entities that shall provide binding
10 arbitration. These arbitrators shall be American Arbitration
11 Association or American Health Lawyers Association trained
12 arbitrators. Both parties must agree on an arbitrator from the
13 Department of Insurance's or its approved entity's list of
14 arbitrators. If no agreement can be reached, then a list of 5
15 arbitrators shall be provided by the Department of Insurance
16 or the approved entity. From the list of 5 arbitrators, the
17 health insurance issuer can veto 2 arbitrators and the
18 provider or facility can veto 2 arbitrators. The remaining
19 arbitrator shall be the chosen arbitrator. This arbitration
20 shall consist of a review of the written submissions by both
21 parties. The arbitrator shall not establish a rebuttable
22 presumption that the qualifying payment amount should be the
23 total amount owed to the provider or facility by the
24 combination of the issuer and the insured, beneficiary, or
25 enrollee. Binding arbitration shall provide for a written
26 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) (Blank).

(g) Section 368a of this Code ~~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.

1 (j) Nothing in this Section shall preclude a beneficiary,
2 insured, or enrollee from assigning benefits to a
3 nonparticipating provider when the notice and consent criteria
4 are satisfied under paragraph (2) of subsection (b-5) or in
5 any other situation not described in subsection (b) or (b-5).
6 (k) Except when the notice and consent criteria are
7 satisfied under paragraph (2) of subsection (b-5), if an
8 individual receives health care services under the situations
9 described in subsection (b) or (b-5), no referral requirement
10 or any other provision contained in the policy or certificate
11 of coverage shall deny coverage, reduce benefits, or otherwise
12 defeat the requirements of this Section for services that
13 would have been covered with a participating provider.
14 However, this subsection shall not be construed to preclude a
15 provider contract with a health insurance issuer, or with an
16 administrator or similar entity acting on the issuer's behalf,
17 from imposing requirements on the participating provider,
18 participating emergency facility, or participating health care
19 facility relating to the referral of covered individuals to
20 nonparticipating providers.
21 (l) Except if the notice and consent criteria are
22 satisfied under paragraph (2) of subsection (b-5),
23 cost-sharing amounts calculated in conformity with this
24 Section shall count toward any deductible or out-of-pocket
25 maximum applicable to in-network coverage.
26 (m) The Department has the authority to enforce the

1 requirements of this Section in the situations described in
2 subsections (b) and (b-5), and in any other situation for
3 which 42 U.S.C. Chapter 6A, Subchapter XXV, Parts D or E and
4 regulations promulgated thereunder would prohibit an
5 individual from being billed or liable for emergency services
6 furnished by a nonparticipating provider or nonparticipating
7 emergency facility or for non-emergency health care services
8 furnished by a nonparticipating provider at a participating
9 health care facility.

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

14 (o) A home rule unit may not regulate payments for ground
15 ambulance service in a manner inconsistent with this Section.
16 This subsection is a limitation under subsection (i) of
17 Section 6 of Article VII of the Illinois Constitution on the
18 concurrent exercise by home rule units of powers and functions
19 exercised by the State.

20 (Source: P.A. 103-440, eff. 1-1-24; 104-248, eff. 8-15-25;
21 revised 9-12-25.)

22 (Text of Section after amendment by P.A. 104-60)

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

25 (a) As used in this Section:

1 "Ancillary services" means:
2 (1) items and services related to emergency medicine,
3 anesthesiology, pathology, radiology, and neonatology that
4 are provided by any health care provider;
5 (2) items and services provided by assistant surgeons,
6 hospitalists, and intensivists;
7 (3) diagnostic services, including radiology and
8 laboratory services, except for advanced diagnostic
9 laboratory tests identified on the most current list
10 published by the United States Secretary of Health and
11 Human Services under 42 U.S.C. 300gg-132(b)(3);
12 (4) items and services provided by other specialty
13 practitioners as the United States Secretary of Health and
14 Human Services specifies through rulemaking under 42
15 U.S.C. 300gg-132(b)(3);
16 (5) items and services provided by a nonparticipating
17 provider if there is no participating provider who can
18 furnish the item or service at the facility; and
19 (6) items and services provided by a nonparticipating
20 provider if there is no participating provider who will
21 furnish the item or service because a participating
22 provider has asserted the participating provider's rights
23 under the Health Care Right of Conscience Act.
24 "Average gross charge rate" means, with respect to
25 nonparticipating ground ambulance service providers, the
26 average of the provider's gross charge rates in place for each

1 individual charge described in subsection (b-15) of this
2 Section for dates of service that fall within the 12-month
3 period ending on June 30 immediately preceding the date on
4 which the reporting of average gross charge rates is required.

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

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

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

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

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

24 (1) in general, an emergency medical screening
25 examination, including ancillary services routinely
26 available to the emergency department to evaluate such

1 emergency medical condition, and such further medical
2 examination and treatment as would be required to
3 stabilize the patient regardless of the department of the
4 hospital or other facility in which such further
5 examination or treatment is furnished; or
6 (2) additional items and services for which benefits
7 are provided or covered under the coverage and that are
8 furnished by a nonparticipating provider or
9 nonparticipating emergency facility regardless of the
10 department of the hospital or other facility in which such
11 items are furnished after the insured, beneficiary, or
12 enrollee is stabilized and as part of outpatient
13 observation or an inpatient or outpatient stay with
14 respect to the visit in which the services described in
15 paragraph (1) are furnished. Services after stabilization
16 cease to be emergency services only when all the
17 conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and
18 regulations thereunder are met.
19 "Emergency ground ambulance service" means ground
20 ambulance service provided by ground ambulance service
21 providers, regardless of whether the patient was transported,
22 if the service was provided pursuant to a request to 9-1-1 or
23 an equivalent telephone number, texting system, or other
24 method of summoning emergency service or if the service
25 provided was provided when a patient's condition, at the time
26 of service, was considered to be an emergency medical

condition as determined by a physician licensed under the Medical Practice Act of 1987.

"Evaluation" means, with respect to emergency ground ambulance service, the provision of a medical screening examination to determine whether an emergency medical condition exists.

"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 service that is described as ground ambulance service by the Centers for Medicare and Medicaid Services and medical nontransportation service, such as evaluation without transport, treatment without transport, or paramedic intercept, and that is, in either case, provided in a vehicle that is licensed as an ambulance under the Emergency Medical Services (EMS) Systems Act or by EMS Personnel assigned to a vehicle that is licensed as an ambulance under the Emergency Medical Services (EMS) Systems Act. "Ground ambulance service" may include any combination of the following: emergency ground ambulance service in a ground ambulance, urgent ground ambulance service, evaluation without treatment, treatment without transport, and paramedic intercept.

"Ground ambulance service provider" means a vehicle service provider under the Emergency Medical Services (EMS) Systems Act that operates licensed ground ambulances for the

1 purpose of providing emergency ground ambulance services,
2 urgent ground ambulances services, or both. "Ground ambulance
3 service provider" includes both ambulance providers and
4 ambulance suppliers as described by the Centers for Medicare
5 and Medicaid Services.

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

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

9 (2) a hospital outpatient department;

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

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

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

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

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

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

26 "Nonparticipating emergency facility" means, with respect

1 to the furnishing of an item or service under a policy of group
2 or individual health insurance coverage, any of the following
3 facilities that does not have a contractual relationship
4 directly or indirectly with a health insurance issuer in
5 relation to the coverage:
6 (1) an emergency department of a hospital;
7 (2) a Freestanding Emergency Center;
8 (3) an ambulatory surgical treatment center as defined
9 in the Ambulatory Surgical Treatment Center Act; or
10 (4) with respect to emergency services described in
11 paragraph (2) of the definition of "emergency services", a
12 hospital.
13 "Nonparticipating ground ambulance service provider"
14 means, with respect to the furnishing of an item or services
15 under a policy of group or individual health insurance
16 coverage, any ground ambulance service provider that does not
17 have a contractual relationship directly or indirectly with a
18 health insurance issuer in relation to the coverage.
19 "Nonparticipating provider" means, with respect to the
20 furnishing of an item or service under a policy of group or
21 individual health insurance coverage, any health care provider
22 who does not have a contractual relationship directly or
23 indirectly with a health insurance issuer in relation to the
24 coverage.
25 "Paramedic intercept" means a service in which a ground
26 ambulance staffed by licensed paramedics rendezvouses with a

1 ground ambulance staffed with nonparamedics to provide
2 advanced life support care. As used in this definition,
3 "advanced life support care" means life support care that is
4 warranted when a patient's condition and need for treatment
5 exceed the basic life support or intermediate life support
6 level of care.
7 "Participating emergency facility" means any of the
8 following facilities that has a contractual relationship
9 directly or indirectly with a health insurance issuer offering
10 group or individual health insurance coverage setting forth
11 the terms and conditions on which a relevant health care
12 service is provided to an insured, beneficiary, or enrollee
13 under the coverage:
14 (1) an emergency department of a hospital;
15 (2) a Freestanding Emergency Center;
16 (3) an ambulatory surgical treatment center as defined
17 in the Ambulatory Surgical Treatment Center Act; or
18 (4) with respect to emergency services described in
19 paragraph (2) of the definition of "emergency services", a
20 hospital.
21 For purposes of this definition, a single case agreement
22 between an emergency facility and an issuer that is used to
23 address unique situations in which an insured, beneficiary, or
24 enrollee requires services that typically occur out-of-network
25 constitutes a contractual relationship and is limited to the
26 parties to the agreement.

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

1 that has a contractual relationship directly or indirectly
2 with a health insurance issuer offering group or individual
3 health insurance coverage setting forth the terms and
4 conditions on which a relevant health care service is provided
5 to an insured, beneficiary, or enrollee under the coverage.

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

9 "Recognized amount" means, except as otherwise provided in
10 this Section, the lesser of the amount initially billed by the
11 provider or the qualifying payment amount.

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

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

16 "Treatment" means, with respect to the provision of
17 emergency ground ambulance service, the provision of an
18 evaluation and either (i) a therapy or therapeutic agent used
19 to treat an emergency medical condition or (ii) a procedure
20 used to treat an emergency medical condition.

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

25 "Visit" means, with respect to health care services
26 furnished to an individual at a health care facility, health

1 care services furnished by a provider at the facility, as well
2 as equipment, devices, telehealth services, imaging services,
3 laboratory services, and preoperative and postoperative
4 services regardless of whether the provider furnishing such
5 services is at the facility.
6 (b) Emergency services. When a beneficiary, insured, or
7 enrollee receives emergency services from a nonparticipating
8 provider or a nonparticipating emergency facility, the health
9 insurance issuer shall ensure that the beneficiary, insured,
10 or enrollee shall incur no greater out-of-pocket costs than
11 the beneficiary, insured, or enrollee would have incurred with
12 a participating provider or a participating emergency
13 facility. Any cost-sharing requirements shall be applied as
14 though the emergency services had been received from a
15 participating provider or a participating facility. Cost
16 sharing shall be calculated based on the recognized amount for
17 the emergency services. If the cost sharing for the same item
18 or service furnished by a participating provider would have
19 been a flat-dollar copayment, that amount shall be the
20 cost-sharing amount unless the provider has billed a lesser
21 total amount. In no event shall the beneficiary, insured,
22 enrollee, or any group policyholder or plan sponsor be liable
23 to or billed by the health insurance issuer, the
24 nonparticipating provider, or the nonparticipating emergency
25 facility for any amount beyond the cost sharing calculated in
26 accordance with this subsection with respect to the emergency

1 services delivered. Administrative requirements or limitations
2 shall be no greater than those applicable to emergency
3 services received from a participating provider or a
4 participating emergency facility.

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

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

1 participating health care facility for any amount beyond
2 the cost sharing calculated in accordance with this
3 subsection with respect to the ancillary services
4 delivered. In addition to ancillary services, the
5 requirements of this paragraph shall also apply with
6 respect to covered items or services furnished as a result
7 of unforeseen, urgent medical needs that arise at the time
8 an item or service is furnished, regardless of whether the
9 nonparticipating provider satisfied the notice and consent
10 criteria under paragraph (2) of this subsection.
11 (2) When a beneficiary, insured, or enrollee utilizes
12 a participating health care facility and receives
13 non-emergency covered health care services other than
14 those described in paragraph (1) of this subsection from a
15 nonparticipating provider during or resulting from the
16 visit, the health insurance issuer shall ensure that the
17 beneficiary, insured, or enrollee incurs no greater
18 out-of-pocket costs than the beneficiary, insured, or
19 enrollee would have incurred with a participating provider
20 unless the nonparticipating provider or the participating
21 health care facility on behalf of the nonparticipating
22 provider satisfies the notice and consent criteria
23 provided in 42 U.S.C. 300gg-132 and regulations
24 promulgated thereunder. If the notice and consent criteria
25 are not satisfied, then:
26 (A) any cost-sharing requirements shall be applied

1 as though the health care services had been received
2 from a participating provider;
3 (B) cost sharing shall be calculated based on the
4 recognized amount for the health care services; and
5 (C) in no event shall the beneficiary, insured,
6 enrollee, or any group policyholder or plan sponsor be
7 liable to or billed by the health insurance issuer,
8 the nonparticipating provider, or the participating
9 health care facility for any amount beyond the cost
10 sharing calculated in accordance with this subsection
11 with respect to the health care services delivered.
12 (b-10) Coverage for ground ambulance services provided by
13 nonparticipating ground ambulance service providers.
14 (1) Any group or individual policy of accident and
15 health insurance amended, delivered, issued, or renewed on
16 or after January 1, 2027 shall provide coverage for both
17 emergency ground ambulance service and urgent ground
18 ambulance service.
19 (2) Beginning on January 1, 2027, when a beneficiary,
20 insured, or enrollee receives emergency ground ambulance
21 services or urgent ambulance services from a
22 nonparticipating ground ambulance service provider, the
23 health insurance issuer shall ensure that the beneficiary,
24 insured, or enrollee shall incur no greater out-of-pocket
25 costs than the beneficiary, insured, or enrollee would
26 have incurred with a participating ground ambulance

provider. Any cost-sharing requirements shall be applied as though the emergency ground ambulance services or urgent ground ambulance services had been received from a participating ground ambulance service provider. Except as otherwise provided in State or federal law, cost sharing shall be calculated based on the lesser of the policy's copayment or coinsurance for an emergency room visit or 10% of the recognized amount. For purposes of this subsection, the recognized amount shall be calculated as provided for in paragraph (3) of this subsection. Except as otherwise provided for in State or federal law, if the cost sharing for the same item or service furnished by a participating ground ambulance provider would have been a flat-dollar copayment, that amount shall be the cost-sharing amount unless the nonparticipating ground ambulance provider has billed a lesser total amount.

(3) Upon reasonable demand by a nonparticipating ground ambulance service provider and after subtracting the beneficiary's, insured's, or enrollee's cost sharing amount, a health insurance issuer shall pay the nonparticipating ground ambulance service provider as follows:

(A) for nonparticipating ground ambulance service providers subject to a unit of local government ~~that has jurisdiction over where the service was provided~~, a rate that is equal to the rate established or

approved by the governing body of the local government providing ground ambulance service ~~having jurisdiction for that area or subarea~~; or

(B) for nonparticipating ground ambulance service providers that are not subject to the jurisdiction of a unit of local government, a rate that is equal to the lesser of (i) the negotiated rate between the nonparticipating ground ambulance service provider and the health insurance issuer; (ii) 85% of the nonparticipating ground ambulance service provider's billed charges; or (iii) the average gross charge rate in effect for the date of service in question for a base charge and, if applicable, a loaded mileage charge, the nonparticipating ground ambulance service provider has filed with the Department of Public Health in accordance with subsection (b-15).

By accepting the payment from the health insurance issuer, the nonparticipating ground ambulance service provider shall not seek any payment from the beneficiary, insured, or enrollee for any amount that exceeds the deductible, coinsurance, or copay for services provided to the beneficiary, insured, or enrollee.

(b-15) Beginning on October 1, 2026, and each October 1 thereafter, each nonparticipating ground ambulance service provider shall file annually with the Department of Public

1 Health, in the form and manner prescribed by the Department of
2 Public Health, its average gross charge rates and any other
3 information required by the Department of Public Health, by
4 rule, for each of the following ground ambulance charge
5 descriptions, as applicable: (1) basic life support, urgent
6 base; (2) basic life support, emergency base; (3) advanced
7 life support, urgent, level 1 base; (4) advanced life support,
8 emergency, level 1 base; (5) advanced life support, emergency,
9 level 2 base; (6) specialty care transport base; (7) emergency
10 response, evaluation without transport base; (8) emergency
11 response, treatment without transport base; (9) emergency
12 response, paramedic intercept base; and (10) loaded mileage,
13 per loaded mile charge for each of the applicable base charge
14 descriptions services. The Department of Public Health shall
15 publish the submitted rate information by January 1, 2027 and
16 every January 1 thereafter. The Department of Public Health
17 may request information from ground ambulance service
18 providers and health insurance issuers regarding factors
19 contributing to the network status of the ground ambulance
20 service providers. The Department of Public Health may, upon
21 the submission of rate information, assess a fee to each
22 ground ambulance service provider that shall not exceed the
23 administrative costs to complete the Department of Public
24 Health's obligations in this subsection. The Department of
25 Public Health may also request information from nationally
26 recognized organizations that provide data on health care

1 costs. The Department of Insurance shall direct the health
2 insurance issuer to the location in which the information
3 reported to the Department of Public Health is stored.

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

22 (d) For bills assigned under subsection (c), the
23 nonparticipating provider or the facility may bill the health
24 insurance issuer for the services rendered, and the health
25 insurance issuer may pay the billed amount or attempt to
26 negotiate reimbursement with the nonparticipating provider or

1 the facility. Within 30 calendar days after the provider or
2 facility transmits the bill to the health insurance issuer,
3 the issuer shall send an initial payment or notice of denial of
4 payment with the written explanation of benefits to the
5 provider or facility. If attempts to negotiate reimbursement
6 for services provided by a nonparticipating provider do not
7 result in a resolution of the payment dispute within 30 days
8 after receipt of written explanation of benefits by the health
9 insurance issuer, then the health insurance issuer or
10 nonparticipating provider or the facility may initiate binding
11 arbitration to determine payment for services provided on a
12 per-bill or batched-bill basis, in accordance with Section
13 300gg-111 of the Public Health Service Act and the regulations
14 promulgated thereunder. The party requesting arbitration shall
15 notify the other party arbitration has been initiated and
16 state its final offer before arbitration. In response to this
17 notice, the nonrequesting party shall inform the requesting
18 party of its final offer before the arbitration occurs.
19 Arbitration shall be initiated by filing a request with the
20 Department of Insurance.

21 (e) The Department of Insurance shall publish a list of
22 approved arbitrators or entities that shall provide binding
23 arbitration. These arbitrators shall be American Arbitration
24 Association or American Health Lawyers Association trained
25 arbitrators. Both parties must agree on an arbitrator from the
26 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) (Blank).

(g) Section 368a of this Code ~~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

1 required to be paid to a provider under Section 368a shall not
2 accrue until after 30 days of an arbitrator's decision as
3 provided in subsection (d), but in no circumstances longer
4 than 150 days from the date the nonparticipating
5 facility-based provider billed for services rendered.
6 (h) Nothing in this Section shall be interpreted to change
7 the prudent layperson provisions with respect to emergency
8 services under the Managed Care Reform and Patient Rights Act.
9 (i) Nothing in this Section shall preclude a health care
10 provider from billing a beneficiary, insured, or enrollee for
11 reasonable administrative fees, such as service fees for
12 checks returned for nonsufficient funds and missed
13 appointments.
14 (j) Nothing in this Section shall preclude a beneficiary,
15 insured, or enrollee from assigning benefits to a
16 nonparticipating provider when the notice and consent criteria
17 are satisfied under paragraph (2) of subsection (b-5) or in
18 any other situation not described in subsection (b) or (b-5).
19 (k) Except when the notice and consent criteria are
20 satisfied under paragraph (2) of subsection (b-5), if an
21 individual receives health care services under the situations
22 described in subsection (b) or (b-5), no referral requirement
23 or any other provision contained in the policy or certificate
24 of coverage shall deny coverage, reduce benefits, or otherwise
25 defeat the requirements of this Section for services that
26 would have been covered with a participating provider.

1 However, this subsection shall not be construed to preclude a
2 provider contract with a health insurance issuer, or with an
3 administrator or similar entity acting on the issuer's behalf,
4 from imposing requirements on the participating provider,
5 participating emergency facility, or participating health care
6 facility relating to the referral of covered individuals to
7 nonparticipating providers.

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

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

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

(o) A home rule unit may not regulate payments for ground ambulance service in a manner inconsistent with this Section. This subsection is a limitation under subsection (i) of Section 6 of Article VII of the Illinois Constitution on the concurrent exercise by home rule units of powers and functions exercised by the State.

(p) ~~(o)~~ Notwithstanding any other provision of law to the contrary, if a beneficiary, insured, or enrollee receives neonatal intensive care from a nonparticipating provider or nonparticipating facility, a health insurance issuer shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than he or she would have incurred with a participating provider or a participating facility, as long as the nonparticipating provider or nonparticipating facility bills the neonatal intensive care as emergency services.

(Source: P.A. 103-440, eff. 1-1-24; 104-60, eff. 1-1-26; 104-248, eff. 8-15-25; revised 9-12-25.)

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.