

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

21 (4) items and services provided by other specialty
22 practitioners as the United States Secretary of Health and
23 Human Services specifies through rulemaking under 42

1 U.S.C. 300gg-132(b)(3);

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

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

10 "Average gross charge rate" means, with respect to
11 nonparticipating ground ambulance service providers, the
12 average of the provider's gross charge rates in place for each
13 individual charge described in subsection (b-15) of this
14 Section for dates of service that fall within the 12-month
15 period ending on June 30 immediately preceding the date on
16 which the reporting of average gross charge rates is required.

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 "Emergency ground ambulance service" means ground
6 ambulance service provided by ground ambulance service
7 providers, regardless of whether the patient was transported,
8 if the service was provided pursuant to a request to 9-1-1 or
9 an equivalent telephone number, texting system, or other
10 method of summoning emergency service or if the service
11 provided was provided when a patient's condition, at the time
12 of service, was considered to be an emergency medical
13 condition as determined by a physician licensed under the
14 Medical Practice Act of 1987.

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

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

22 "Ground ambulance service" means both medical
23 transportation service that is described as ground ambulance
24 service by the Centers for Medicare and Medicaid Services and
25 medical nontransportation service, such as evaluation without
26 transport, treatment without transport, or paramedic

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

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

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

- 20 (1) a hospital as defined in 42 U.S.C. 1395x(e);
21 (2) a hospital outpatient department;
22 (3) a critical access hospital certified under 42
23 U.S.C. 1395i-4(e);
24 (4) an ambulatory surgical treatment center as defined
25 in the Ambulatory Surgical Treatment Center Act; or
26 (5) any recipient of a license under the Hospital

1 Licensing Act that is not otherwise described in this
2 definition.

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

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

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

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

18 (1) an emergency department of a hospital;

19 (2) a Freestanding Emergency Center;

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

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

25 "Nonparticipating ground ambulance service provider"
26 means, with respect to the furnishing of an item or services

1 under a policy of group or individual health insurance
2 coverage, any ground ambulance service provider that does not
3 have a contractual relationship directly or indirectly with a
4 health insurance issuer in relation to the coverage.

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

11 "Paramedic intercept" means a service in which a vehicle
12 licensed under the Emergency Medical Services (EMS) Systems
13 Act ~~ground ambulance~~ staffed by licensed advanced life support
14 EMS Personnel ~~paramedics~~ rendezvouses with a ground ambulance
15 staffed with basic life support or intermediate life support
16 EMS Personnel ~~nonparamedics~~ to provide advanced life support
17 care. As used in this definition, "advanced life support care"
18 means life support care that is warranted when a patient's
19 condition and need for treatment exceed the basic life support
20 or intermediate life support level of care.

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

1 under the coverage:

- 2 (1) an emergency department of a hospital;
- 3 (2) a Freestanding Emergency Center;
- 4 (3) an ambulatory surgical treatment center as defined
- 5 in the Ambulatory Surgical Treatment Center Act; or
- 6 (4) with respect to emergency services described in
- 7 paragraph (2) of the definition of "emergency services", a
- 8 hospital.

9 For purposes of this definition, a single case agreement

10 between an emergency facility and an issuer that is used to

11 address unique situations in which an insured, beneficiary, or

12 enrollee requires services that typically occur out-of-network

13 constitutes a contractual relationship and is limited to the

14 parties to the agreement.

15 "Participating ground ambulance service provider" means

16 any ground ambulance service provider that has a contractual

17 relationship directly or indirectly with a health insurance

18 issuer offering group or individual health insurance coverage

19 setting forth the terms and conditions on which a relevant

20 health care service is provided to an insured, beneficiary, or

21 enrollee under the coverage. As used in this definition, a

22 single case agreement between a ground ambulance service

23 provider and a health insurance issuer that is used to address

24 unique situations in which an insured, beneficiary, or

25 enrollee requires services that typically occur out-of-network

26 constitutes a contractual relationship and is limited to the

1 parties of the agreement.

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

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

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

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

26 "Stabilize" means "stabilization" as defined in Section 10

1 of the Managed Care Reform and Patient Rights Act.

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

4 "Treatment" means, with respect to the provision of
5 emergency ground ambulance service, the provision of an
6 evaluation and either (i) a therapy or therapeutic agent used
7 to treat an emergency medical condition or (ii) a procedure
8 used to treat an emergency medical condition.

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

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

20 (b) Emergency services. When a beneficiary, insured, or
21 enrollee receives emergency services from a nonparticipating
22 provider or a nonparticipating emergency facility, the health
23 insurance issuer shall ensure that the beneficiary, insured,
24 or enrollee shall incur no greater out-of-pocket costs than
25 the beneficiary, insured, or enrollee would have incurred with
26 a participating provider or a participating emergency

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

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

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

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

25 (2) When a beneficiary, insured, or enrollee utilizes
26 a participating health care facility and receives

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

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

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

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

26 (b-10) Coverage for ground ambulance services provided by

1 nonparticipating ground ambulance service providers.

2 (1) Any group or individual policy of accident and
3 health insurance amended, delivered, issued, or renewed on
4 or after January 1, 2027 shall provide coverage for both
5 emergency ground ambulance service and urgent ground
6 ambulance service.

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

1 participating ground ambulance provider would have been a
2 flat-dollar copayment, that amount shall be the
3 cost-sharing amount unless the nonparticipating ground
4 ambulance provider has billed a lesser total amount.

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

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

18 (B) for nonparticipating ground ambulance service
19 providers that are not subject to the jurisdiction of
20 a unit of local government, a rate that is equal to the
21 lesser of (i) the negotiated rate between the
22 nonparticipating ground ambulance service provider and
23 the health insurance issuer; (ii) 85% of the
24 nonparticipating ground ambulance service provider's
25 billed charges; or (iii) the average gross charge rate
26 in effect for the date of service in question for a

1 base charge and, if applicable, a loaded mileage
2 charge, the nonparticipating ground ambulance service
3 provider has filed with the Department of Public
4 Health in accordance with subsection (b-15).

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

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

1 per loaded mile charge for each of the applicable base charge
2 descriptions services. The Department of Public Health shall
3 publish the submitted rate information by January 1, 2027 and
4 every January 1 thereafter. The Department of Public Health
5 may request information from ground ambulance service
6 providers and health insurance issuers regarding factors
7 contributing to the network status of the ground ambulance
8 service providers. The Department of Public Health may, upon
9 the submission of rate information, assess a fee to each
10 ground ambulance service provider that shall not exceed the
11 administrative costs to complete the Department of Public
12 Health's obligations in this subsection. The Department of
13 Public Health may also request information from nationally
14 recognized organizations that provide data on health care
15 costs. The Department of Insurance shall direct the health
16 insurance issuer to the location in which the information
17 reported to the Department of Public Health is stored.

18 (c) Notwithstanding any other provision of this Code,
19 except when the notice and consent criteria are satisfied for
20 the situation in paragraph (2) of subsection (b-5), any
21 benefits a beneficiary, insured, or enrollee receives for
22 services under the situations in subsection (b), (b-5),
23 (b-10), or (b-15) are assigned to the nonparticipating
24 providers, nonparticipating ground ambulance service provider,
25 or the facility acting on their behalf. Upon receipt of the
26 provider's bill or facility's bill, the health insurance

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

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

1 300gg-111 of the Public Health Service Act and the regulations
2 promulgated thereunder. The party requesting arbitration shall
3 notify the other party arbitration has been initiated and
4 state its final offer before arbitration. In response to this
5 notice, the nonrequesting party shall inform the requesting
6 party of its final offer before the arbitration occurs.
7 Arbitration shall be initiated by filing a request with the
8 Department of Insurance.

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

1 decision within 45 days after the request is filed with the
2 Department of Insurance. Both parties shall be bound by the
3 arbitrator's decision. The arbitrator's expenses and fees,
4 together with other expenses, not including attorney's fees,
5 incurred in the conduct of the arbitration, shall be paid as
6 provided in the decision.

7 (f) (Blank).

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

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

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

1 appointments.

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

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

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

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

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

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

21 (p) ~~(o)~~ Notwithstanding any other provision of law to the
22 contrary, if a beneficiary, insured, or enrollee receives
23 neonatal intensive care from a nonparticipating provider or
24 nonparticipating facility, a health insurance issuer shall
25 ensure that the beneficiary, insured, or enrollee shall incur
26 no greater out-of-pocket costs than he or she would have

1 incurred with a participating provider or a participating
2 facility, as long as the nonparticipating provider or
3 nonparticipating facility bills the neonatal intensive care as
4 emergency services.

5 (Source: P.A. 103-440, eff. 1-1-24; 104-60, eff. 1-1-26;
6 104-248, eff. 8-15-25; revised 11-21-25.)

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

9 (215 ILCS 125/4-15) (from Ch. 111 1/2, par. 1409.8)

10 Sec. 4-15. (a) No contract or evidence of coverage for
11 basic health care services delivered, issued for delivery,
12 renewed, or amended by a Health Maintenance Organization shall
13 exclude coverage for ground ambulance service as defined in
14 Section 356z.3a of the Illinois Insurance Code ~~emergency~~
15 ~~transportation by ambulance. For the purposes of this Section,~~
16 ~~the term "emergency" means a need for immediate medical~~
17 ~~attention resulting from a life threatening condition or~~
18 ~~situation or a need for immediate medical attention as~~
19 ~~otherwise reasonably determined by a physician, public safety~~
20 ~~official or other emergency medical personnel.~~

21 (b) Payments to nonparticipating ground ambulance service
22 providers shall be as described in subsection (b-10) of
23 Section 356z.3a of the Illinois Insurance Code ~~Upon reasonable~~
24 ~~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.)