**Section 4520.110 Emergency Services**

a) For purposes of determining compliance with Section 65 of the Act, timely determination shall mean a determination is made within 30 days after the health care plan receives a claim for emergency services if no additional information is needed to determine the emergency services meet the definition of an emergency medical condition. In the event additional information is necessary to make the determination, the health care plan shall request the medical record documenting the presenting symptoms at the time care was sought within 15 days after receipt of the emergency services claim and make a determination within 30 days after its receipt.

b)If a group health care plan offering group or individual health insurance, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan shall cover emergency services in a manner that those services will be provided without imposing a requirement under the plan for prior authorization of services or any limitation on coverage when the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

c) In addition to complying with the coverage requirements provided in 50 Ill. Adm. Code 2051.310(a)(6)(J), if emergency services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if the services were provided in-network. (Section 2719A(b) and (c)(ii) of the Public Health Service Act (42 USC 300 gg-19(1)))

(Source: Amended at 38 Ill. Reg. 2253, effective January 2, 2014)