AN ACT concerning insurance.

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

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

(215 ILCS 5/356z.3)

Sec. 356z.3. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing

charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of this Code. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(Source: P.A. 95-331, eff. 8-21-07.)

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

Sec. 356z.3a. Nonparticipating facility-based physicians and providers.

(a) For purposes of this Section, "facility-based provider" means a physician or other provider who provide radiology, anesthesiology, pathology, neonatology, or emergency department services to insureds, beneficiaries, or enrollees in a participating hospital or participating ambulatory surgical treatment center.

(b) When a beneficiary, insured, or enrollee utilizes a

participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services.

(c) If a beneficiary, insured, or enrollee agrees in writing, notwithstanding any other provision of this Code, any benefits a beneficiary, insured, or enrollee receives for services under the situation in subsection (b) are assigned to the nonparticipating facility-based providers. The insurer or health plan shall provide the nonparticipating provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment or coinsurance amounts owed by the insured, beneficiary or enrollee. The insurer or health plan shall pay any reimbursement directly to the nonparticipating facility-based provider. The nonparticipating facility-based physician or provider shall not bill the beneficiary, insured, or enrollee, except for applicable deductible, copayment, or coinsurance amounts that would apply if the beneficiary, insured, or enrollee utilized a participating physician or provider for

covered services. If a beneficiary, insured, or enrollee specifically rejects assignment under this Section in writing to the nonparticipating facility-based provider, then the nonparticipating facility-based provider may bill the beneficiary, insured, or enrollee for the services rendered.

(d) For bills assigned under subsection (c), the nonparticipating facility-based provider may bill the insurer or health plan for the services rendered, and the insurer or health plan may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating facility-based provider. If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the insurer or health plan, then an insurer or health plan or nonparticipating facility-based physician or provider may initiate binding arbitration to determine payment for services provided on a per bill basis. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the Department of Insurance.

(e) The Department of Insurance shall publish a list of approved arbitrators or entities that shall provide binding

arbitration. These arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree on an arbitrator from the Department of Insurance's list of arbitrators. If no agreement can be reached, then a list of 5 arbitrators shall be provided by the Department of Insurance. From the list of 5 arbitrators, the insurer can veto 2 arbitrators and the provider 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. 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) This Section 356z.3a does not apply to a beneficiary, insured, or enrollee who willfully chooses to access a nonparticipating facility-based physician or provider for health care services available through the insurer's or plan's network of participating physicians and providers. In these circumstances, the contractual requirements for nonparticipating facility-based provider reimbursements will apply.

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d) any interest

required to be paid 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 date the nonparticipating facility-based provider billed for services rendered.