(b) Definitions

In this section:

(1) Continuing care patient

The term ''continuing care patient'' means an individual who, with respect to a provider or facility—

(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(B) is undergoing a course of institutional or inpatient care from the provider or facility;

(C) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) is or was determined to be terminally ill (as determined under section 1395x(dd)(3)(A) of this title) and is receiving treatment for such illness from such provider or facility.

(2) Serious and complex condition

The term ''serious and complex condition'' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that is—[1]

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(3) Terminated

The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

(July 1, 1944, ch. 373, title XXVII, § 2799A–3, as added Pub. L. 116–260, div. BB, title I, § 113(a), Dec. 27, 2020, 134 Stat. 2868.)

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 113(e) of div. BB of Pub. L. 116–260, set out as a note under section 9818 of Title 26, Internal Revenue Code.

§ 300gg–114. Maintenance of price comparison tool

A group health plan or a health insurance issuer offering group or individual health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.

(July 1, 1944, ch. 373, title XXVII, § 2799A–4, as added Pub. L. 116–260, div. BB, title I, § 114(a), Dec. 27, 2020, 134 Stat. 2874.)

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 114(d) of div. BB of Pub. L. 116–260, set out as a note under section 9819 of Title 26, Internal Revenue Code.

§ 300gg–115. Protecting patients and improving the accuracy of provider directory information

(a) Provider directory information requirements

(1) In general

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall—

(A) establish the verification process described in paragraph (2);

(B) establish the response protocol described in paragraph (3);

(C) establish the database described in paragraph (4); and

(D) include in any directory (other than the database described in subparagraph (C)) containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

(2) Verification process

The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process—

(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 300gg–139 of this title.

(3) Response protocol

The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic,

[1] So in original. Probably should be ''a condition that—''.

web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

(B) retains such communication in such individual's file for at least 2 years following such response.

(4) Database

The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, a database on the public website of such plan or issuer that contains—

(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

(B) provider directory information with respect to each such provider and facility.

(5) Information

The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

(6) Definition

For purposes of this subsection, the term ''provider directory information'' includes, with respect to a group health plan and a health insurance issuer offering group or individual health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

(7) Rule of construction

Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

(b) Cost-sharing for services provided based on reliance on incorrect provider network information

(1) In general

For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan or coverage if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant, beneficiary, or enrollee and item or service, the plan or coverage—

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage had such item or service been furnished by a participating provider; and

(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

(2) Criteria described

For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, are the following:

(A) The participant, beneficiary, or enrollee received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

(B) The information was not provided, in accordance with subsection (a), to the participant, beneficiary, or enrollee and the participant, beneficiary, or enrollee requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

(c) Disclosure on patient protections against balance billing

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 300gg–111 of this title applies—

(1) information in plain language on—

(A) the requirements and prohibitions applied under sections 300gg–131 and 300gg–132 of this title (relating to prohibitions on balance billing in certain circumstances);

(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

(C) the requirements applied under section 300gg–111 of this title; and

(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

(July 1, 1944, ch. 373, title XXVII, § 2799A–5, as added Pub. L. 116–260, div. BB, title I, § 116(a), Dec. 27, 2020, 134 Stat. 2878.)

§ 300gg–117. Other patient protections

(a) Choice of health care professional

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) Access to pediatric care

(1) Pediatric care

In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or group or individual health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(2) Construction

Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(c) Patient access to obstetrical and gynecological care

(1) General rights

(A) Direct access

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) Obstetrical and gynecological care

A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) Application of paragraph

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or health insurance coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) Construction

Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(July 1, 1944, ch. 373, title XXVII, § 2799A–7, as added Pub. L. 116–260, div. BB, title I, § 102(a)(2), Dec. 27, 2020, 134 Stat. 2770.)

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note under section 8902 of Title 5, Government Organization and Employees.

§ 300gg–118. Air ambulance report requirements

(a) In general

Each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury—

(1) not later than the date that is 90 days after the last day of the first calendar year be-