

**(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 or facility, 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 1861(dd)(3)(A) of the Social Security Act) 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 or beneficiary under a group health plan—

(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—

(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 non-renewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

(Added Pub. L. 116-260, div. BB, title I, § 113(b)(1), Dec. 27, 2020, 134 Stat. 2870.)

**Editorial Notes**

## REFERENCES IN TEXT

Section 1861(dd)(3)(A) of the Social Security Act, referred to in subsec. (b)(1)(E), is classified to section 1395x(dd)(3)(A) of Title 42, The Public Health and Welfare.

**Statutory Notes and Related Subsidiaries**

## EFFECTIVE DATE

Pub. L. 116-260, div. BB, title I, § 113(e), Dec. 27, 2020, 134 Stat. 2873, provided that: “The amendments made by subsections (a), (b), and (c) [enacting this section, section 1185g of Title 29, Labor, and section 300gg-113 of Title 42, The Public Health and Welfare] shall apply with respect to plan years beginning on or after January 1, 2022.”

**§ 9819. Maintenance of price comparison tool**

A group health plan 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, 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 with respect to the furnishing of a specific item or service by any such provider.

(Added Pub. L. 116-260, div. BB, title I, § 114(b)(1), Dec. 27, 2020, 134 Stat. 2874.)

**Statutory Notes and Related Subsidiaries**

## EFFECTIVE DATE

Pub. L. 116-260, div. BB, title I, § 114(d), Dec. 27, 2020, 134 Stat. 2875, provided that: “The amendments made by this section [enacting this section, section 1185h of Title 29, Labor, and section 300gg-114 of Title 42, The Public Health and Welfare] shall apply with respect to plan years beginning on or after January 1, 2022.”

**§ 9820. 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 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 the information described in paragraph (5).

**(2) Verification process**

The verification process described in this paragraph is, with respect to a group health plan, a process—

(A) under which, not less frequently than once every 90 days, such plan 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 2799B-9 of the Public Health Service Act.

**(3) Response protocol**

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