

**(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

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, 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; 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, 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 should consult the database described in paragraph (4) with respect to such plan or contact such plan to obtain the most current provider directory information with respect to such plan.

**(6) Definition**

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

**(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 or beneficiary of a group health plan by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan 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 or beneficiary and item or service, the plan—

(A) shall not impose on such participant or beneficiary 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 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 or beneficiary of a group health plan by a nonparticipating provider or a nonparticipating facility, are the following:

(A) The participant or beneficiary 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 or beneficiary and the participant or beneficiary requested through the response protocol described in subsection (a)(3) of the plan 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 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 9816 applies—

(1) information in plain language on—

(A) the requirements and prohibitions applied under sections 2799B-1 and 2799B-2 of the Public Health Service Act (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 or beneficiary of such plan with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan after receiving payment from the plan for such item or service and any applicable cost sharing payment from such participant or beneficiary; and

(C) the requirements applied under section 9816; 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.

(Added Pub. L. 116-260, div. BB, title I, §116(c), Dec. 27, 2020, 134 Stat. 2884.)

#### Editorial Notes

##### REFERENCES IN TEXT

Section 2799B-9 of the Public Health Service Act, referred to in subsec. (a)(2)(C), is classified to section 300gg-139 of Title 42, The Public Health and Welfare.

Sections 2799B-1 and 2799B-2 of the Public Health Service Act, referred to in subsec. (c)(1)(A), are classified to sections 300gg-131 and 300gg-132, respectively, of Title 42, The Public Health and Welfare.

#### § 9822.<sup>1</sup> Other patient protections

##### (a) Choice of health care professional

If a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan shall permit each participant and beneficiary 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 or beneficiary under a group health plan if the plan requires or provides for the designation of a participating primary care provider for the child, the plan 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.

###### (2) Construction

Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan 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 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 or beneficiary 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 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.

###### (B) Obstetrical and gynecological care

A group health plan 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 described in this paragraph is a group health plan that—

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

(B) requires the designation by a participant or beneficiary 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 with respect to coverage of obstetrical or gynecological care; or

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

(Added Pub. L. 116-260, div. BB, title I, §102(c)(2), Dec. 27, 2020, 134 Stat. 2795.)

#### Statutory Notes and Related Subsidiaries

##### EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB 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.

#### § 9823. Air ambulance report requirements

##### (a) In general

Each group health plan shall submit to the Secretary, jointly with the Secretary of Labor and the Secretary of Health and Human Services—

(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rule-making described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

(2) not later than the date that is 90 days after the last day of the calendar year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

##### (b) Information described

For purposes of subsection (a), information described in this subsection, with respect to a group health plan is each of the following:

(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(A) Whether such services were furnished on an emergent or nonemergent basis.

(B) Whether the provider of such services is part of a hospital-owned or sponsored pro-

<sup>1</sup> So in original. No section 9821 has been enacted.