

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

(2) Requirements

The requirements of this paragraph are that the plan or issuer—

(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

(i) the 90-day period beginning on such date; or

(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(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 spe-

cialized 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 non-renewal 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.)

Statutory Notes and Related Subsidiaries

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.)

Statutory Notes and Related Subsidiaries

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);

¹ So in original. Probably should be “a condition that—”.