



The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements

*Center for Consumer
Information & Insurance
Oversight (CCIIO)*



Agenda

- Background: No Surprises Act Training Series
- Continuity of Care Requirements
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- Public Disclosure Requirements
- Questions



Legal Disclaimers

The information provided in this presentation is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This presentation summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Legal Disclaimers (continued)

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Background: No Surprises Act Training Series



Overview of the No Surprises Act

The No Surprises Act* introduced new requirements for providers, facilities, and providers of air ambulance services to protect individuals from surprise medical bills. These requirements:

- Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances;
- Require providers and facilities to provide good-faith estimates of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good-faith estimates to the individual's plan or issuer;
- Create a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;
- Require certain providers and facilities to publicly disclose restrictions on balance billing; and
- Limit billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information.

* Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act).

Scope of individuals protected under the No Surprises Act

Beginning January 1, 2022, these No Surprises Act requirements will apply to items and services provided to most individuals enrolled in **private or commercial health coverage**, like:

- Employment-based group health plans (both self-insured and fully insured)
- Individual or group health coverage on or outside the Federal or State-based Exchanges
- Federal Employee Health Benefit (FEHB) health plans
- Non-federal governmental plans sponsored by state and local government employers
- Certain church plans within IRS jurisdiction
- Student health insurance coverage [as defined at 45 CFR 147.145]

Scope of individuals protected under the No Surprises Act (continued)

Some requirements also apply to providers and facilities with respect to uninsured (or self-pay) individuals, like requirements that providers and facilities provide good faith estimates for scheduled care, or upon request.

Requirements under the No Surprises Act don't apply to beneficiaries or enrollees in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills. The protections also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree-only plans; or account-based group health plans.

No Surprises Act Training Series

The training series is intended to educate providers and facilities on these major provisions of the No Surprises Act.

***Focus of today's presentation**

Summary of Provision	Statute and Regulatory Citation
Prohibition on balance billing for emergency services provided by out-of-network providers or emergency facilities	PHS Act section 2799B-1 45 C.F.R § 149.410
Prohibition on balance billing for non-emergency services by out-of-network providers at certain in-network health care facilities	PHS Act section 2799B-2 45 C.F.R. § 149.420
Prohibition on balance billing for air ambulance services by out-of-network air ambulance service providers	PHS Act section 2799B-5 45 C.F.R. § 149.440
*Public disclosure of individual protections against balance billing	PHS Act section 2799B-3 45 C.F.R. § 149.430
*Restrictions on how much providers and facilities bill individuals in situations where the provider's or facility's network contract with the individual's plan or issuer is terminated during continuing care	PHS Act section 2799B-8
*Restrictions on how much providers and facilities bill individuals in situations where an individual inadvertently receives care from an out-of-network provider or facility based on inaccurate provider directory information	PHS Act section 2799B-9
Provision of good faith estimates of charges to uninsured or self-pay individuals in advance of scheduled items or services or upon request	PHS Act section 2799B-6 45 C.F.R. § 149.610
The patient-provider dispute resolution process	PHS Act section 2799B-7 45 C.F.R § 149.620
The independent dispute resolution process	PHS Act section 2799A-1 45 C.F.R § 149.510

Continuity of Care Requirements



Overview of the No Surprises Act's continuity of care requirements

In general, if a provider or facility ceases to be an in-network provider because of a termination of a contract, certain continuity of care protections apply to an individual who meets the definition of a **continuing care patient** and is furnished items or services by such provider or facility for which the individual's plan or issuer provides coverage.

For the continuing care patient whose provider's or facility's contract termination leads to a change in network status, the plan or issuer must:

- Timely notify each individual enrolled who is a continuing care patient of the termination and their right to elect continued transitional care from the provider or facility;
- Provide each individual enrolled who is a continuing care patient an opportunity to notify the plan or issuer of the need for transitional care; and
- Permit the continuing care patient to elect to continue to have the same benefits provided, under the same terms and conditions as would have applied under the plan or coverage had the termination not occurred, with respect to the course of treatment furnished by the provider or facility.

Overview of the No Surprises Act's continuity of care requirements

The election may last until the earlier of 90 days (starting on the date their plan or issuer notifies them of the change in network status); or the date on which such individual is no longer a continuing care patient with the provider or facility.

In this situation, the No Surprises Act requires that a continuing care patient's treating provider or health care facility must:

- Accept payment from the plan or issuer (and cost sharing from the individual) for items and services as payment in full;
- Continue to adhere to all policies, procedures, and quality standards imposed by the plan or issuer for an individual as if the termination hadn't occurred.

We will review what each of these terms mean throughout the presentation.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Scope of providers and facilities that must comply with the No Surprises Act continuity of care requirements

The No Surprises Act continuity of care requirements apply to health care providers and health care facilities. The statute doesn't exempt any categories of providers or facilities from this requirement.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Scope of individuals considered continuing care patients

Continuing care patients are defined as individuals who, with respect to a provider or facility, are at least one of the following:

1. Undergoing treatment from the provider or facility for a **serious and complex condition**, defined as:
 - 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.
 - b. In the case of a chronic illness or condition, a condition that is:
 - i. Life-threatening, degenerative, potentially disabling, or congenital; and
 - ii. Requires specialized medical care over a prolonged period of time.

Scope of individuals considered continuing care patients (continued)

2. Undergoing a course of institutional or inpatient care from the provider or facility.
3. 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.
4. Pregnant and undergoing treatment for pregnancy from the provider or facility.
5. Terminally ill and receiving treatment for such illness from the provider or facility.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

When continuing care patients are eligible for continuity of care protections under the No Surprises Act

Protections apply for **continuing care patients** who are receiving covered services or items from a treating **provider or health care facility**, and their treating provider or health care facility experiences a change in network status due to one of the following:

- The provider or health care facility's contractual relationship with the individual's plan or issuer is **terminated**;
- The provider or health care facility's terms of participation in the plan or coverage change, resulting in a termination of benefits with respect to the provider or health care facility;
- A group health plan's contract with a health insurance issuer offering health insurance coverage in connection with the plan is **terminated**, resulting in a loss of benefits provided under such plan with respect to the provider or health care facility.

When continuing care patients are eligible for continuity of care protections under the No Surprises Act (continued)

Terminated is defined as, 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.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Knowledge check

Joan is a 30-year-old female who is insured through her employer. She is 30 weeks pregnant and following up with her obstetrician regularly. At her next visit, Joan is told that her obstetrician no longer maintains a contract with her insurer due to the obstetrician voluntarily not renewing her contract.

Would continuity of care protections apply to Joan with respect to her obstetrician?

Knowledge check answer

Yes, continuity of care protections would apply to Joan with respect to the obstetrician, as the contract between the obstetrician and the plan was terminated for reasons other than failure to meet applicable quality standards or for fraud. In scenarios where a contract is terminated due to failure to meet quality standards or fraud, continuity of care protections wouldn't apply.

In this example, Joan meets the standard for a continuing care patient since she is pregnant and undergoing treatment for pregnancy from the obstetrician. As a result, she is eligible for continuity of care protections because she is receiving covered services from a treating provider who has since been terminated from her plan's network.

Effective date of continuity of care requirements

The No Surprises Act continuity of care protections apply to **services furnished in plan years beginning on or after January 1, 2022.**

Rulemaking implementing this provision of the No Surprises Act won't be published **until after January 1, 2022.**

Any rulemaking to implement continuity of care requirements will include a prospective applicability date that provides plans, issuers, providers, and facilities with a reasonable amount of time to comply with new requirements.

Providers and facilities are expected to implement the requirements using a **good faith, reasonable** interpretation of the statute prior to issuance of rulemaking.

Provider Directory Requirements



Overview of the No Surprises Act provider directory requirements

Under the No Surprises Act, providers and health care facilities must generally:

- Refund enrollees amounts paid in excess of in-network cost-sharing amounts with interest, if the enrollee has inadvertently received out-of-network care due to inaccurate provider directory information, the provider or facility billed the enrollee for an amount in excess of in-network cost-sharing amounts, and the enrollee paid the bill.
- Maintain business processes to submit provider directory information at specified times to support plans and issuers in maintaining accurate, up to date provider directories.

Overview of the No Surprises Act provider directory requirements (continued)

A provider is permitted to require, as part of the terms of a contract or contract termination with a plan or issuer that the plan or issuer:

- **Remove the provider** from the directory **at the time of termination of contract.**
- **Bear financial responsibility** for providing **inaccurate network status information** to an enrollee, as applicable.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Scope of providers and facilities that must comply with the No Surprises Act provider directory requirements

The No Surprises Act provider directory requirements apply to health care providers and health care facilities. The statute doesn't exempt any categories of providers or facilities from this requirement.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Provider business processes to support accurate directory information

At a minimum, providers and health care facilities must submit provider directory information to a plan or issuer:

- When the provider or health care facility begins a network agreement with a plan or issuer with respect to certain coverage;
- When the provider or health care facility terminates a network agreement with a plan or issuer with respect to certain coverage;
- When there are material changes to the content of provider directory information of the provider or health care facility;
- At any other time (including upon the request of plan or issuer) determined appropriate by the provider, health care facility, or the Secretary of Health and Human Services (HHS).

Provider business processes to support accurate directory information (continued)

Providers and health care facilities are required to have business processes in place to ensure timely provision of provider directory information to plans or issuers **no later than January 1, 2022.**

Rulemaking to implement this requirement will not take place until **after January 1, 2022.** In the meantime, providers may have to work with health plans or issuers to make good faith efforts when these circumstances are reported.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Provider directory information that providers and facilities must share

Information that providers and health care facilities provide to a plan provider directory must include:

- Names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers; and
- Names, addresses, telephone numbers, and digital contact information of **each medical group, clinic, or health care facility contracted to participate** in any of the networks of the group health plan or health insurance coverage involved.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Knowledge check

A pulmonologist recently began a network agreement with a new health plan.

Is the pulmonologist required to submit provider directory information to the plan?

Knowledge check answer

Yes, under the No Surprises Act, the pulmonologist is required to submit provider directory information (i.e. the provider's name, address(es), specialty, telephone number(s), and digital contact information) to a plan or issuer when they begin a network agreement with a plan or issuer with respect to certain coverage. There are also additional circumstances when a provider must submit provider directory information to a plan or issuer.

Cost-sharing limits for services provided based on incorrect provider directory information

Under the No Surprises Act, if an individual relies on incorrect provider directory information and, as a result, receives items or services from an **out-of-network provider or out-of-network health care facility**:

1. Their plan or issuer must:

- Limit cost-sharing to in-network terms that would apply had items or services been furnished by an in-network provider;
- Apply the deductible or out-of-pocket maximums as if the provider or health care facility were in-network.

2. Their provider or health care facility must:

- Not bill an individual more than their in-network cost-sharing.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Provider requirements for refunding individuals

If 1) an individual relies on incorrect provider directory information, 2) the provider submits a bill to the individual that is more than the in-network cost-sharing amount, and 3) the individual pays the bill:

- The provider must reimburse the individual for the **full amount paid by the individual in excess of the in-network cost-sharing amount, plus interest.**
 - The interest rate will be determined by the Secretary of HHS through rulemaking.

Provider requirements for refunding individuals (continued)

This requirement applies to items or services furnished based on incorrect provider directory information in **plan years beginning on or after January 1, 2022.**

Rulemaking to implement this requirement will not take place until **after January 1, 2022.** In the meantime, providers may have to work with health plans or issuers to make good faith efforts when these circumstances are reported.

Note: The Departments anticipate issuing future rulemaking implementing requirements for this No Surprises Act provision.

Knowledge check

A cardiologist has recently terminated their practice's contract with a health plan. The cardiologist asks that the plan remove the practice from the directory as part of the terms of contract termination.

Is the cardiologist permitted to ask the plan to remove their name from the directory upon contract termination?

Knowledge check answer

Yes, under the No Surprises Act, the cardiologist is permitted to require in the terms of a contract or contract termination that a plan or issuer remove the provider's name from the directory at the time of termination of contract. Additionally, the cardiologist is contractually permitted to require that the plan or issuer bear financial responsibility for providing inaccurate network status information to an enrollee.

Public Disclosure Requirements



Overview of required disclosures

The No Surprises Act requires **health care providers** and **health care facilities** to publicly share written disclosures, distributed through multiple methods, outlining key protections.

These disclosures must include information on:

1. The prohibitions on balance billing for emergency or non-emergency services with which the provider or health care facility must comply;
2. Any state laws governing balance billing with which the provider or health care facility must comply; and
3. Contact information for state and/or federal agencies that an individual can contact to report a suspected provider or health care facility violation of the balance billing protections in the No Surprises Act or state laws governing surprise medical bills.

Overview of required disclosures (continued)

These disclosures are intended to help give individuals a clear understanding of their protections under the balance billing provisions of the No Surprises Act and who to contact if they believe those protections have been violated.

These disclosure requirements do NOT apply to **providers of air ambulance services**. However, HHS strongly encourages air ambulance providers to also make disclosures available to individuals.

Scope of providers that must comply with the No Surprises Act public disclosure requirements

The following types of **providers** must comply with the No Surprises Act public disclosure requirements:

- Physicians;
- Other health care providers acting within their scope of practice under applicable State law (e.g. a certified nurse practitioner or physician assistant), but doesn't include a provider of air ambulance services.

Providers aren't required to make the disclosures:

- If the provider doesn't furnish items or service at a health care facility, or in connection with visits at health care facilities.
- To individuals to whom the provider furnishes items or services, if such items or services aren't furnished at a health care facility, or in connection with a visit at a health care facility.

Scope of facilities that must comply with the No Surprises Act public disclosure requirements

The following types of **health care facilities** must comply with the public disclosure requirements:

- **Hospitals** (including critical access hospitals);
- **Hospital outpatient departments;**
- **Ambulatory surgical centers;**
- **Emergency departments of hospitals; and**
- **Independent freestanding emergency departments.**

Required methods of disclosure

Under the No Surprises Act, providers and health care facilities must share required disclosure information through 3 methods:

1. Public signage posted prominently at the provider or facility's location (e.g., in a central location, like where individuals check-in, pay bills, etc.);
2. Posting on a public, easily accessible website without any requirements for account sign-up, passwords, or paywalls; and
3. One-page notice provided directly to individuals enrolled in a group health plan or group or individual health insurance coverage that must be delivered in person or by email or mail, based on the individual's preference.

We will review each method on the following slides.

Requirements for use of public signage

Providers and health care facilities must publicly display disclosure information on a sign posted in a prominent location.

- This should be a central location, like where individuals schedule care, check-in for appointments, or pay bills.

Requirements for posting on a public website

Providers and health care facilities must post the required disclosure or a link to the disclosure on a searchable homepage of their public website.

- The website should be free of charge.
- Visitors should **NOT** have to do any of the following to access this website:
 - Establish a user account, password, or other credentials;
 - Accept any terms or conditions; or
 - Submit any personal identifying information like name or email address.

Requirements for one-page notice

Providers and health care facilities must provide a written notice to individuals with a group health plan or group or individual market health insurance coverage, as well as Federal Employees Health Benefits (FEHB) plans.

- This notice should be provided in-person, by mail, or by email (as chosen by the individual).
- The notice should be limited to one double-sided page and must use a font size of 12-points or larger.

Providers and health care facilities must provide individuals with the one-page notice **NO LATER** than the date & time when they request payment from the individual.

- This includes requests for co-payments or co-insurance made at the time of the visit.

If payment isn't requested from an individual, providers and health care facilities must provide the disclosure notice **NO LATER** than the date a claim is submitted for payment to a health plan or issuer.

Key exceptions to disclosure requirements

- Providers that never furnish items or services at a health care facility or in connection with visits to a health care facility do **NOT** need to fulfill the No Surprises Act disclosure requirements.
- Providers are only required to share No Surprises Act disclosures with individuals to whom they furnish services or items, and only in the situations where the services they provide are furnished at a health care facility or provided in connection with a visit to a health care facility.
- If a provider or health care facility does **NOT** have a publicly accessible location, they are **NOT** required to publicly display the disclosure content via signage.
- If the provider or health care facility does **NOT** have a website, they are **NOT** required to share the disclosure content on a public website.

Knowledge check

A gastroenterologist provides services at a local ambulatory surgical center three days per week. The gastroenterologist maintains a public website for their practice.

Is the gastroenterologist required to share disclosure information on their public website?

Knowledge check answer

Yes, as a provider who furnishes items or services at a health care facility, the gastroenterologist is required to share disclosure information on their public website. Under the No Surprises Act, providers and health care facilities must post the required disclosure or a link to the disclosure on a searchable homepage of their public website.

A provider isn't required to share disclosure information if they don't furnish items or services at a health care facility, or in connection with visits at health care facilities. Additionally, a provider isn't required to share disclosure information to individuals to whom the provider furnishes items or services, if such items or services aren't furnished at a health care facility, or in connection with a visit at a health care facility.

Model disclosure notices

HHS has issued a model disclosure notice that providers and health care facilities can choose to, but aren't required to, use.

This model disclosure notice was published as part of CMS Form Number 10780 and is available for download [here](#).

HHS has also encouraged states to develop model language to assist providers and health care facilities in meeting disclosure requirements related to the No Surprises Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate]

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

Language accessibility

All disclosures must use clear and understandable language.

- Providers and health care facilities are encouraged to use plain language in their disclosure notices and test the notice for clarity and usability when possible.
- Providers can find plain language, accessibility, and language access resources at <https://www.plainlanguage.gov/guidelines/>.

Health care facilities must make reasonable efforts to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services like translation of written content into languages other than English.

Health care facilities that receive federal financial assistance must also comply with federal civil rights laws that prohibit discrimination, including section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973.

Special rule to prevent duplicate provision of disclosures

Providers and health care facilities can enter into written agreements stating that the health care facility is responsible for providing the one-page disclosure to individuals on behalf of both the health care facility and the provider, in situations where the provider delivers care at the facility.

This single disclosure would need to outline restrictions on balance billing that apply to both the health care facility and the provider.

If a written agreement is in place and a health care facility fails to provide full, timely disclosure information, then **ONLY the facility would be considered in violation of the No Surprises Act.**

- Providers with these agreements should still monitor a health care facility's adherence to the disclosure requirements and notify the applicable state authority or HHS if there is a question of non-compliance.

Main takeaways

The No Surprises Act protects continuing care patients in circumstances where their treating provider's or health care facility's plan network status changes, allowing a 90-day transitional care period. During this time:

- Health plans and issuers must limit cost-sharing to in-network terms.
- Treating providers and facilities must accept cost-sharing and payment from plans and issuers as payment in full.

The No Surprises Act protects individuals who inadvertently seek care from an out-of-network provider or health care facility after relying on inaccurate provider directory information. In these circumstances:

- Their health plan or issuer must limit cost-sharing to in-network terms.
- The provider or health care facility must refund enrollees amounts paid in excess of in-network cost sharing amounts with interest, if the provider or facility billed the enrollee for an amount in excess of in-network cost-sharing amounts, and the enrollee paid the bill.

Main takeaways (continued)

The No Surprises Act requires that providers and health care facilities publicly share written disclosures, distributed through multiple methods, outlining No Surprises Act key protections.

Note: The Departments anticipate issuing future rulemaking implementing requirements related to continuity of care requirements and provider directory requirements.

Questions



Send any questions about the provider requirements and provider enforcement to provider_enforcement@cms.hhs.gov.

Appendix: Glossary



Glossary

Term	Definition	Citation in the CFR/ Section of PHSA	Originating No Surprises Act Rule
Continuing care patient	<p>The term ‘continuing care patient’ means an individual who, with respect to a provider or facility—</p> <p>(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;</p> <p>(B) is undergoing a course of institutional or inpatient care from the provider or facility;</p> <p>(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;</p> <p>(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or</p> <p>(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.</p>	PHSA Sec. 2799A-3(b)(1)	N/A
Cost sharing	<p>The amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but doesn’t include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that aren’t covered under a group health plan or health insurance coverage.</p>	45 CFR 149.30	<u>Requirements Related to Surprise Billing; Part I IFC</u>

Glossary

Term	Definition	Citation in the CFR/ Section of PHSA	Originating No Surprises Act Rule
Emergency department of a hospital	Includes a hospital outpatient department that provides emergency services.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Health care facility	<p>With respect to a group health plan or group or individual health insurance coverage, in the context of non-emergency services, is each of the following:</p> <p>(1) A hospital (as defined in section 1861(e) of the Social Security Act);</p> <p>(2) A hospital outpatient department;</p> <p>(3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and</p> <p>(4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.</p>	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Independent freestanding emergency department	A health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—(1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (2) Provides any emergency services as described in § 149.110(c)(2)(i).	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Out-of-network emergency facility	An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 149.110(c)(2)(ii) are included as emergency services), that doesn't have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC

Glossary

Term	Definition	Citation in the CFR/ Section of PHSA	Originating No Surprises Act Rule
Out-of-network provider	Any physician or other health care provider who doesn't have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Physician or health care provider	A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable state law, but doesn't include a provider of air ambulance services.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Provider of air ambulance services	An entity that is licensed under applicable state and federal law to provide air ambulance services.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Serious and complex condition	<p>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—</p> <p>(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</p> <p>(B) in the case of a chronic illness or condition, a condition that is—</p> <p>(i) is life-threatening, degenerative, potentially disabling, or congenital; and</p> <p>(ii) requires specialized medical care over a prolonged period of time.</p>	PHSA Sec. 2799A-3(b)(2)	N/A
Terminated	The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but doesn't include a termination of the contract for failure to meet applicable quality standards or for fraud.	PHSA Sec. 2799A-3(b)(3)	N/A