Exhibits

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Exhibit 1: Sample Notice – Explanation of the Requirements under the Consolidated Appropriations Act and the New "Transparency in Coverage" Regulations for Participants

This **Sample Notice** is for Participants of GHPs and individual health insurance plans.

EXPLANATION OF THE REQUIREMENTS UNDER THE CONSOLIDATED APPROPRIATIONS ACT AND THE NEW "TRANSPARENCY IN COVERAGE" REGULATIONS

Introduction

You and your covered dependents have been provided new protections under the Consolidated Appropriations Act, 2021 (CAA) as participants in a Group Health Plan (GHP) or an individual insurance policy. The CAA included the "No Surprises Act," which includes additional protections.

Most of these changes will not be applicable until the plan or policy year beginning in 2022, some are scheduled to apply sooner, and others do not apply until 2023 or 2024.

In addition, in keeping with the theme of transparency, near the end of 2020 the Department of Labor (DOL), the Treasury, and Health and Human Services (HHS) issued the final "Transparency in Coverage" regulations, which include their own set of new disclosure requirements for GHPs and individual health insurance.

This notice provides an explanation of the provisions and your protections.

Expanded Protections for You and Your Covered Dependents

Prevention of Surprise Bills for you seeking Care from an Emergency Room or Freestanding Emergency Care Facility

When you seek treatment at an emergency department, sometimes you cannot control whether the health care provider providing treatment, or the related facility services and their health care providers, are in your plan or policy's network. To reduce the dollar amount of unexpected bills that you receive after seeking emergency care from out-of-network health care providers, the new changes provide that the amounts paid for emergency care will now be treated as in-network for calculating reimbursement, must be provided without prior authorization and such in-network treatment provisions will apply until you are stabilized only if certain requirements are satisfied.

GHPs, health insurers, health care providers, and health care facilities are required to make publicly available (post on a public website of the plan or issuer, and include information in plain language on:

1. the restrictions on balance billing in certain circumstances,
2. any applicable state law protections against balance billing,
3. the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
4. information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

An out-of-network provider will only be permitted to bill you more than the in-network cost-sharing amount for care provided after you are stabilized if certain conditions are met and if the provider gives you a notice of the provider's network status and provides you or your health plan an estimate of charges within certain specified timeframes and obtains your written consent prior to the delivery of care.

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Note: This new process also applies to out-of-network providers of non-emergency Services at In-Network Facilities, air ambulance services and is discussed below.

Out-of-Network Providers of Non-Emergency Services at In-Network Facilities

For non-emergency services provided by an out-of-network provider during a visit at an in-network facility, the non-emergency services provider is required to hold you harmless for amounts beyond the in-network cost-sharing requirement unless the out-of-network provider gives you a notice and obtains your prior consent.

To satisfy the notice and consent exception for out-of-network providers of non-emergency services to bill you an amount greater than the in-network cost-sharing amount (an exception that applies only to this category of out-of-network non-emergency services at in-network facilities), the out-of-network provider must give you (1) written or electronic notice of the provider's out-of-network status, (2) a list of in-network providers that the covered individual could see instead, and (3) a good faith estimate of the your charges must be provided at least 72 hours prior to your scheduled appointments, or if scheduled after, on the same day as your appointment no later than three hours prior to services being rendered. You must sign a consent to receive the services from the out-of-network provider and acknowledge that you received the written or electronic notice.

There is a notice and consent exception for all ancillary services or items, or services furnished as a result of unforeseen, urgent medical needs that arise after you consented to the out-of-network non-emergency care at an in-network facility, which are always subject to the surprise and balance billing prohibitions applicable to emergency services provided by out-of-network health care providers. Furthermore, the notice and consent exception does not apply to any items and services provided by an out-of-network provider when there was no alternative in-network provider at the facility who could furnish the covered item or service. Such services are considered to be "ancillary services." Other services considered to be "ancillary services," and thus always subject to the billing prohibitions by out-of-network providers of amounts beyond the in-network cost-sharing requirement, include:

- services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner).
- items and services provided by assistant surgeons, hospitalists, and intensivists.
- diagnostic services, including radiology and laboratory services; and
- items and services provided by certain specialty practitioners (which will be specified through future rulemaking).

Prevention of Surprise Bills for Air Ambulance Services

If your health plans cover in-network air ambulance services, then you can only be required to pay the in-network cost-sharing amount for the air ambulance, and those amounts paid will be applied to your deductible and out-of- pocket-maximum (OOPM) under the health plan. Air ambulance providers will not be able to balance bill you for the remaining amounts. Note: This provision does not apply to ground ambulance claims.

Claims from an out-of-network air ambulance claim must count against your in-network deductibles and cost-sharing limits

As a result, if you receive air ambulance services which are paid for by a group or individual health plan in a plan or policy year beginning on or after January 1, 2022, you should not be held liable for any

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amount in excess of their cost-sharing limits under their group or individual health plan (deductible, out-of-pocket maximum, co-insurance, or copayments) from an out-of-network air ambulance service provider.

Choice of Health Care Provider

There are new provisions that protect your access to pediatricians, obstetricians, and gynecologists as primary care provider You have a right to direct access to pediatricians, obstetricians, and gynecologists as your primary care provider, if they are in-network.

Continuity of Care

If you are in the midst of a course of medical care, you may have new protections. These new protections will apply if you or your beneficiary are a continuing care patient receiving care from a network provider for (1) a serious and complex condition, (2) a course of institutional or inpatient care from a provider or facility, (3) a nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery, (4) pregnancy and is undergoing a course of treatment for the pregnancy, or (5) a determined terminal illness and is receiving treatment for such illness from a provider or facility, and such provider or facility's contract to be a network provider terminates or expires for any reason other than fraud by such provider or facility, then the following requirements must be met:

- You, as a continuing care patient, must receive notice that your provider or facility is leaving the network and you may be protected for continuing care at the time the provider or facility's contract terminates and inform you of your right to elect continued transitional care from such provider or facility.
- You must be provided with an opportunity to notify the plan or insurer of your need for transitional care.
- You must be allowed to elect to continue to have your 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 had the provider or facility's contract not terminated.

You will continue to receive such transitional coverage beginning on the date you received notice of the contract termination and continue until the earlier of 90 days after your receipt of such notice, or the date you are no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility. The health care provider caring for the continuing care patient is required to accept payment from such plan for services and items furnished to the continuing care patient as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the plan.

Miscellaneous Disclosure Requirements

New Transparency Requirement

Effective for plan or policy years beginning on or after January 1, 2022, group and individual health plan identification cards must include the applicable major medical deductible and applicable out-of-pocket maximum, as well as a telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and maximum out-of-pocket limits. Additional deductibles and out-of-pocket maximum limits could also be provided on a website that is accessed

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through a Quick Response code (commonly referred to as a QR code) on the participant's, beneficiary's, or covered individual's ID card or through a hyperlink in the case of a digital ID card.

This requirement has been delayed until guidance is released sometime later in 2022

Advanced Explanation of Benefits (EOB) Requirements

Beginning with the first plan or policy year beginning on or after January 1, 2022, when any health care provider notifies a group or individual health plan that you are scheduled to receive services, the health plan must notify you no later than one business day after receiving such notice (the deadline varies depending on when the service is scheduled as compared to when the notice is received) in clear and understandable language whether or not the health care provider or facility is an in-network provider for the plan. In addition, the advanced explanation of benefits is required to be provided to you and must include all of the following information:

- Whether or not the provider or facility is in-network with respect to the health plan for the item or service and, if in-network, the contracted rate or coverage (based on the billing and diagnostic codes provided by the provider or facility) and if it is out-ot-network, then a description of how the individual may obtain information on providers and facilities that are in-network, if any.
- The good faith estimate included in the notification received from the provider or facility based on such codes.
- A good faith estimate of the amount the plan is responsible for and the amount of any covered individual cost sharing (including with respect to the deductible and any copayment or coinsurance obligation (as of the date of the notification).
- A good faith estimate of the amount that you have incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan (as of the date of such notification).
- If the item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage, a disclaimer that the coverage is subject to that medical management technique.
- A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change.
- Any other information or disclaimer the plan determines appropriate that is consistent with information and disclaimers required under this section of the Act.

Time frames: The above notice must be provided to you not later than 1 business day after the provider or facility gives notice to the health plan or, if the item or service was scheduled in time, then at least 10 business days before the item or service is to be furnished. If the notification was made pursuant to your request, then the time is 3 business days after the date on which the plan receives the notification.

This requirement has been delayed until guidance is released later in 2022.

Price Comparison Tool for In-Network Services Required

For plan or policy years beginning on or after January 1, 2022 (According to FAQs, the Departments will delay enforcement until plan or policy years beginning on or after January 1, 2023), a health plan is required to offer price comparison guidance by telephone and make available on its website a price comparison tool that (to the extent practicable) allows you, for the plan year, geographic region, and its

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participating providers, to compare the amount of cost sharing that you would be responsible for paying with respect to the furnishing of a specific item or service by any such provider.

Provider Directory Information Improvement

Effective for plan or policy years beginning on or after January 1, 2022, each health plan must establish: (i) a verification process; (ii) a response protocol; and (iii) a provider database and include in any directory (other than the database) specified provider directory information. Under the verification process, the health plan—not less frequently than once every 90 days—must verify and update the provider directory information in a database. It must establish a procedure for the removal from the database of a provider or facility if the plan has been unable to verify the information during a period specified by the health plan. The database must be updated within 2 business days of the health plan receiving information that a provider or facility has changed its network status. Group health plans will need to enhance website information and other communication

Health care providers and facilities are now required to put in place a business process to provide timely updates to provider directories at both the beginning and termination of a network relationship. If a health care provider or facility bills you greater than the in-network rate and you pay the bill, the health care provider is required to repay you the amount paid in excess of the in-network rate for the services or treatment with interest at the rate specified by federal government.

Mental Health and Substance Use Disorder Benefits

If your group and individual health plans provide mental health or substance abuse disorder benefits and impose any Non-Quantitative Treatment Limitations (NQTLs) on such benefits (i.e., restrictions not tied to dollar value or frequency) your group or individual health plan must perform and document a comparative analysis. The comparative analysis is required to contain the following information (copied directly from the legislation):

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification;

2. The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits;

3. he evidentiary standards used for the factors identified in clause (2), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits;

4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification; and

5. The specific findings and conclusions reached by the group health plan or health insurer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

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As a participant under a group health plan, you may be able to request a copy of this comparative analysis and the plan may have provide you with a copy within thirty days or be subject to penalties under federal law.

Public Disclosure Requirement

For plan or policy years beginning on or after January 1 2022, group health plans and insurers offering non-grandfathered group health plans and individual health policies are required to make detailed pricing information available to the public in three separate machine-readable files. These files must detail the in-network rates the plan negotiates with network providers, the allowed amounts paid in the past to out-of-network providers, and the negotiated rates and historical net prices for prescription drugs, respectively. The information must be displayed in standardized format and updated monthly.

This requirement has been delayed for plan or policy years beginning on after July 1, 2022.

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Exhibit 2: Compliance Tool – Summary of Action Steps to Comply

The table below provides a summary checklist of the principal requirements under the 2021 Consolidated Appropriations Act (CAA) and Transparency in Coverage regulations. Use this tool as a project management guide to assure your organization has addressed each of the compliance requirements. Requirements that apply to grandfathered health plans are indicated with a leading "*".

Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
*Surprise Billing and Independent Dispute Resolution (IDR) Plan or policy years beginning on or after January 1, 2022	Emergency Services Provided by a Out-of-Network Provider/Facility: If a plan covers emergency services in an emergency department, a plan must cover emergency services provided by a nonparticipating provider/facility without prior authorization and with in-network cost-sharing until the participant is stable. The plan must apply cost-sharing towards the participant's In-Network deductible and out-of- pocket maximum (OOPM). Neither the nonparticipating facility nor the nonparticipating provider can balance bill the participant. Non-emergency Services Provided by Nonparticipating Providers at Participating Facilities: The plan must cover non- emergency services provided by a nonparticipating provider at a participating facility with in-network cost-sharing. The plan must apply cost-sharing towards the participant's In-Network deductible and OOPM. The non-participating provider cannot balance bill the participant unless the non-participating provider provides notice and the individual consents. This notice and consent exception does not apply if the provider is an ancillary provider (e.g., anesthesiologist), there is no participating provider available at the participating facility, or the care is for unforeseen or urgent services.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to delineate responsibilities regarding surprise billing, timely payments/denials, negotiations, and arbitration. • Consider adding language regarding who makes decisions (e.g., the TPA/insurance company, the plan, or both). • Consider adding language regarding notification requirements (e.g., if the plan receives a claim from a nonparticipating provider/facility, the TPA will notify the plan prior to		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
	The plan must make payment or notice of denial within 30 days after the nonparticipating provider/facility transmits a bill for services where the provider or facility transmit a clean claim. The plan and the nonparticipating provider/facility may engage in open negotiations for 30 days regarding the nonparticipating claim. If negotiations fail, the plan or nonparticipating provider/facility may request IDR. The losing party must pay the entire cost of the IDR. Insured plans may be subject to state surprise billing laws.	paying/denying the claim). • Consider adding language about who pays for IDR. • Amend plan documents and SPDs, as necessary. • For self-funded plans, consider whether to reevaluate stop-loss arrangements because of increased plan costs.		
*Surprise Air Ambulance Bills Plan or policy years beginning on or after January 1, 2022	If the plan covers air ambulance services from participating providers, the plan must cover air ambulance services from a nonparticipating provider with in-network cost-sharing. The plan must apply cost-sharing towards the participant's In-Network deductible and OOPM. The air ambulance nonparticipating provider cannot balance bill the participant. The plan must make a payment or notice of denial within 30 days after the air ambulance nonparticipating provider transmits a bill for services where the provider or facility transmit a clean claim. The plan and air ambulance nonparticipating provider may engage in open negotiations for 30 days regarding the air ambulance claim.	See above action items for Surprise Billing.		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
	If negotiations fail, the plan or the nonparticipating air ambulance provider may request IDR. The losing party must pay the entire cost of the IDR.			
*Reporting Requirements Regarding Air Ambulance Services 90 days after the last day of the first calendar year beginning on or after the date final rules are issued	Plans must provide detailed reports to DOL, HHS, and Treasury, as applicable, regarding air ambulance claims	• Confirm in writing that TPAs (or insurers for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this reporting requirement		
External Review for Surprise Billing January 1, 2022	Plans must expand their external review process to include adverse benefit determinations for the surprise bills and surprise air ambulance bills.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Amend plan documents and SPDs, as necessary.		
*Protections Against Provider Discrimination January 1, 2022	Under the Affordable Care Act, plans must not discriminate with respect to plan participation or coverage against any health care provider acting within the scope of the provider's license or certification. DOL, HHS, and Treasury must issue proposed regulations implementing this requirement by January 1, 2022, and issue final regulations six months after the comment period.	• Comply with guidance, once issued, regarding protections against provider discrimination		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
*Continuity of Care Plan or policy years beginning on or after January 1, 2022	Plans must take various actions if participants who are "continuing care patients" lose their benefits with respect to a participating provider/facility because the plan's contractual relationship with the provider/facility terminates or benefits with respect to the provider/facility terminate. These actions include: (1) notifying the continuing care patient about the termination and the participant's right to transitional care; (2) providing the continuing care patient with an opportunity to notify the plan of their need for transitional care; and (3) allowing the continuing care patient to elect to continue to have benefits under the plan on the same terms and conditions as if the termination had not occurred for 90 days (or, if earlier, the date the participant is no longer a continuing care patient). A "continuing care patient" is an individual who, with respect to a provider/facility, is scheduled for nonelective surgery or is undergoing treatment for a serious and complex condition, a pregnancy, or a terminal illness.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement. • Amend plan documents and SPDs, as necessary. • For self-funded plans, consider whether to reevaluate stop-loss arrangements because of potentially increased plan costs.		
*Identification Cards with Deductibles and Out-of-Pocket Limit Information Plan or policy years beginning on or after	Plans must include information regarding d the applicable major medical deductible and applicable out-of-pocket maximum, as well as a telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and maximum out-of-pocket limits. Additional deductibles and out-of-pocket maximum limits could also be	• Confirm in writing that TPAs (or insurance companies for insured plans) that provide ID cards will comply with these rules and discuss any associated cost increases. • Review and revise service contracts with TPAs (or insurance		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
January 1, 2022	provided on a website that is accessed through a Quick Response code (commonly referred to as a QR code) on the participant's, beneficiary's, or covered individual's ID card or through a hyperlink in the case of a digital ID card.	contracts for insured plans) to clarify responsibilities regarding this requirement		
*Advanced Explanation of Benefits Plan or policy years beginning on or after January 1, 2022 (This requirement is delayed until guidance is released later in 2022)	Plans must provide participants, upon request, with an advanced EOB for scheduled services that generally explains the estimated costs for the item or service and the applicable cost-sharing requirements.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss any associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement. • Amend plan documents and SPDs, as necessary		
*Price Comparison Tool Plan or policy years beginning on or after January 1, 2022 (Delayed date plan or policy years beginning on or after January 1, 2023),	Plans must offer price comparison guidance by phone and a price comparison tool online so participants can compare cost-sharing amounts for specific items and services furnished by a provider.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss any associated cost increases. TPAs (or insurance companies) may need to update any existing price comparison tools that they offer. • Review and revise service contracts with TPAs (or insurance contracts for insured		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
		plans) to clarify responsibilities regarding this requirement.		
*Provider Directory and Coverage Information Requests Plan or policy years beginning on or after January 1, 2022	Plans must establish a database on a public website that includes a list of providers and facilities that have a direct or indirect contractual relationship with the plan and directory information. Plans must verify and update the database at least every 90 days and remove any providers or facilities if the plan cannot verify their information. Plans must also include information on print directories that the directory was accurate as of the date of publication and that the participant should consult the plan's database to obtain the most current information. Plans must establish a response protocol for responding within one business day to a participant who requests information regarding whether a provider or facility is in-network and also save the communication in the participant's file for at least two years. Plans must impose in-network cost-sharing and apply the deductible or OOPM to an item or service provided by a nonparticipating provider or nonparticipating facility if the plan's database, directory, or response protocol incorrectly indicated that the item or service was in-network. Plans must make publicly available, post on a public website, and include on each EOB, information regarding	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss any associated cost increases. TPAs (or insurance companies) may need to update any existing online databases that they offer. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify who will maintain the online database, revise any print directories, respond to participant requests for information, and provide disclosures regarding protections against balance billing. • Amend plan documents and SPDs, as necessary. • For self-funded plans, consider whether to reevaluate stop-loss arrangements because of potentially increased plan costs.		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
	prohibitions on balance billing in certain circumstances and, if applicable, additional information required under state law.			
Removal of Gag Clauses December 27, 2020 (Attestations not submitted until 2022)	Plans cannot enter into agreements that directly or indirectly restrict them from: (1) providing cost or quality of care information to referring providers, plan sponsors, participants, or individuals eligible to become participants; or (2) accessing deidentified claims and encounter information with respect to participants. Nonetheless, such agreements may include reasonable restrictions on public disclosure. Plans must submit an annual attestation indicating compliance with this transparency rule.	• Review and revise, as applicable, agreements with health insurance providers, third-party administrators, and other service providers offering access to provider networks to ensure compliance with this transparency rule. • Submit an annual attestation indicating compliance.		
*Disclose Direct and Indirect Compensation for new contracts entered or renewed after December 27, 2021	Disclosures for brokers and other consultants providing services to certain group health plans. Under the Act, "covered service providers" must disclose their "direct" and "indirect" compensation above $1,000 received during the term of the contract or arrangement to a responsible plan fiduciary of a "covered health plan.	• Group health plans should begin working in coordination with covered service providers to determine whether these new disclosure requirements will apply to them and, if so, what indirect compensation must be disclosed. • In preparing to comply with these new disclosure rules, affected parties may seek guidance in the disclosures practices that apply to qualified retirement plans.		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
*Mental Health Parity and Addiction Equity Act (MHPAEA) Comparative Analysis February 10, 2021	Plans that offer medical and surgical benefits and mental health or substance use disorder benefits and impose nonquantitative treatment limitations (NQTLs) on the mental health or substance use disorder benefits must be able to provide a detailed comparative analysis regarding compliance with the MHPAEA's NQTL rule upon request from the Department of Labor (DOL), Health and Human Services (HHS), or applicable state agency.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. If the TPA cannot assist, consider possible vendors to hire for this purpose. • Consider conducting an internal audit to ensure compliance with MHPAEA.		
Pharmacy Benefit and Drug Cost Reporting December 27, 2021 (delayed until December 27, 2022)	Plans must report certain information related to plan medical costs and prescription drug spending to DOL, HHS, and Treasury. The first report is due on December 27, 2021, and subsequent reports are due no later than June 1 of every subsequent year. Eighteen months after December 27, 2021, DOL, HHS, and Treasury will post a report on their respective websites on prescription drug reimbursements, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases.	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this reporting requirement. • Use the report posted on DOL, HHS, and Treasury websites as a comparison tool to review and revise current plan medical spending and drug costs and as a reference point for future requests for proposal.		

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Requirement/ Effective Date	Description	Action Items to Consider	Date Completed	Notes
Machine-readable files In-network rates Out-of-network allowable amounts Delayed until plan or policy years beginning on or after July 1, 2022 Prescription drug rates Delayed until after issuance of further rulemaking	Does not apply to grandfathered plans. Requires plans and issuers to make available on a public website three machine-readable files. Must be accessible without having to set up an account or password and without having to provide any identifying information. In-network rates includes negotiated rates and if applicable, underlying fee schedule rates or derived amounts. Out-of-network allowed amounts includes historical allowed amounts and billed charges for services provided for a 90-day period beginning 180 days prior to publication. Prescription drug file includes negotiated rates, and historical net prices inclusive of rebates, for a 90-day period beginning 180 days prior to publication.	• Confirm in writing that TPAs or insurers will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs or insurers to clarify responsibilities regarding these requirements.		

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Exhibit 3: Sample Language – Surprise Bills from Patients Seeking Care from Emergency Room or Freestanding Emergency Care Facility – Plan Document Provisions

The language below can be modified as necessary and used to amend Plan Documents to reflect the requirements of the No Surprises Act to prevent surprise bills from patients seeking care at emergency rooms or freestanding emergency care facilities:

"Effective **[Date]**, amounts paid for emergency care are treated as in-network for calculating reimbursement as determined under methodology set forth in the No Surprises Act, and applicable regulations thereunder, until the **[Participant, Covered Individual, etc.]** is stabilized. Once the **[Participant, Covered Individual, etc.]** is stabilized, amounts paid for emergency care are treated as in-network only if certain requirements are satisfied.

Such services shall be provided by emergency departments and freestanding emergency care facilities without requiring any prior authorization by the Plan, and the cost-sharing that a Participant must pay shall not exceed the amount that an In-Network provider or facility would charge. The Plan shall cover such emergency services without regard to any other term of conditions of coverage, other than exclusion or coordination of benefits or a permitted affiliation or waiting period.

A claim for these services must now be initially paid or denied within 30 days of submission by the health care provider or issue a notice of denial of payment. The Plan shall monitor when the emergency claim was received, and the initial and final payments are due in addition to the ERISA claim and appeal timing deadlines."

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Exhibit 4: Sample Language – Surprise Bills from Patients Seeking Care from Emergency Room or Freestanding Emergency Care Facility – Summary Plan Description Provisions

The language below can be modified as necessary and used to amend Summary Plan Descriptions to reflect the requirements of the NSA to prevent surprise bills from patients seeking care at emergency rooms or freestanding emergency care facilities:

"Any claims paid for emergency care will now be treated as In-network for calculating reimbursement as determined under a methodology set forth in the No Surprises Act, and applicable regulations thereunder, until you are stabilized.

For any emergency services you incurred after you have been stabilized, you will not be balance billed for any services provided by an Out-of-Network Provider provided certain conditions are met, including giving you timely notice and obtaining your written consent in advance to the services.

Such services provided at emergency departments and freestanding emergency care facilities will be paid without requiring any prior authorization by the Plan, and the cost-sharing you must pay shall not exceed the amount that an In-Network provider or facility would charge. Such emergency services shall be provided without regard to any other terms of conditions of coverage, other than plan exclusions or coordination of benefits, a permitted affiliation, a waiting period."

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Exhibit 5: Sample Language – Surprise Bills from Patients Seeking Care from Emergency Room or Freestanding Emergency Care Facility – Administrative Services Agreement Provisions

The language below can be modified as necessary and used to amend Administrative Services Agreements to reflect the requirements of the No Surprises Act to prevent surprise bills from patients seeking care at emergency rooms or freestanding emergency care facilities:

"Effective **[Date]**, the Claims Administrator shall pay any claims for emergency care as In-network for calculating reimbursement as determined under methodology set forth in the No Surprises Act, and applicable regulations thereunder, until the Participant is stabilized.

The Claims Administrator shall pay for such services provided by emergency departments and freestanding emergency care facilities without requiring any prior authorization by the Plan, and the cost-sharing that a Participant must pay shall not exceed the amount that an In-Network provider or facility would charge for the services whether a prior authorization is required for any of the items or services. The Claims Administrator shall make sure that such emergency services are covered without regard to any other terms or conditions of coverage other than exclusion or coordination of benefits or a permitted affiliation or waiting period.

The Claims Administrator shall either initially pay the claim within 30 days of submission by the health care provider or facility or issue a notice of denial of payment. The Claims Administrator shall monitor when the emergency claim was received, and when the initial and final payments are due in addition to the ERISA claim and appeal timing deadlines.

In determining the total amount to be paid by the Plan to the provider or facility, including any cost-sharing, to (in order of priority) is limited to (in order of priority):

- an amount determined by an applicable All-Payer Model (APM) Agreement, or
- an amount determined by specified state law, or
- an amount agreed upon by the plan/issuer and provider/facility, or (if none apply)
- an amount determined by an Independent Dispute Resolution (IDR) entity

The Claims Administrator shall pay for services and items furnished by out-of-network providers or facilities where there is no state law for determining the payment rate, then the out-of-network provider or facility and the Claims Administrator will enter an Independent Dispute Resolution (IDR) process operated by a certified IDR entity which shall determine the amount to be paid in accordance with the Consolidated Appropriations Act

The Claims Administrator shall have an obligation to inform the provider or facility what the qualifying payment amount is, provide a certification that the qualifying payment amount was determined in accordance with the methodology required under the No Surprises Act and provide any other information to the provider or facility as required by federal regulations.

For any emergency care incurred after the Participant has been stabilized, the Claims Administrator shall advise that the Participant shall not be responsible for any amount in excess of the in-network amount unless the provider or facility obtains the Participant's informed consent in accordance with the notice and consent requirements an any other conditions under the No Surprises Act and applicable regulations before any additional services are rendered.

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The Claims Administrator must make sure that the Participant signs a consent to receive the services from the out-of-network provider or facility and acknowledge in a timely manner that he or she received the written or electronic notice."

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Exhibit 6: Sample Notice – Qualified Payment Amount Notice

QUALIFIED PAYMENT AMOUNT NOTICE

To: **[Name of Provider or Facility]**

From: **[Name of Plan or Insurer]**

Re: **[Name of Participant or Insured]**

[Type of Item or Service]

[Date of Item or Service]

[Amount Billed]

We have received your recent statement for the above item or service on **[Date]**.

We have decided to deny payment for the amount contained in your statement and apply the Qualified Payment Amount (QPA) to the billed item/service.

The QPA will apply to each billed item/service.

The QPA will apply for purposes of the recognized or cost-sharing amount.

Each QPA will be determined in compliance with the interim final rule methodology under Section 102 of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act (CAA), 2021.

You may initiate a 30-day negotiation period and may request Independent Dispute Resolution after the end of the negotiation period.

To determine the QPA, the above **[Plan or Insurer]** has:

- Included Information about whether the QPA includes rates not set on an FFS basis and whether the QPA for those items/services were determined using a fee schedule or derived amount.
- Identified the related service code if a new service code is used.
- Identified any database used to determine the QPA.
- Excluded risk-sharing, bonus, penalty or other incentive-based or retrospective payments or payment adjustments.

If you wish to enter into negotiations or have any questions regarding the factors used to determine the QPA, please contact:

[Name]

[Title]

[Name of Plan or Insurer]

[Address]

[City, State, Zip]

[Telephone Number]

[Email Address]

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Exhibit 7: Compliance Tool – Summary of State Laws Prohibiting Balance Billing

Summary of State Laws Prohibiting Balance Billing

Currently, 18 states have comprehensive laws providing protection against balance billing for out-of-network services. and 15 states have laws providing partial protection. 17 states have no state law providing protection against balance billing. It should be noted that some states without a state law may still have an All-Payer Model Agreement which must be considered. Brief descriptions of the laws are provided below. These laws do not apply to self-funded plans. However, a few states as noted below allow self-funded plans to opt into the state law relating to prohibitions on balance billing. Unless otherwise noted, these laws apply to both HMO and PPO covered individuals. Note that this list reflects the status of state laws that are effective as of February 2021 and should be monitored for any changes.

States with Comprehensive Protections

- **California –** The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services 2) non-emergency services at in-network facilities and 3) air ambulance providers. It does not apply to non-emergency services where covered individual consents in writing. Any consent must meet certain minimum requirements. State provides minimum payment standards. The state also has a dispute resolution process for non-emergency services. There is a voluntary, non-binding arbitration for emergency services which is rarely used.
- **Colorado –** The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services 2) ground ambulance providers unless fully publicly funded and 3) non-emergency services at in-network facilities. Protections do not apply if covered individual voluntarily uses out-of-network provider but must provide mandatory disclosure with EOB meeting certain requirements. The state provides minimum payment standards. The state has a dispute resolution process.
- **Connecticut** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. Protections do not apply if covered individual voluntarily uses out-of-network provider. The state provides minimum payment standards.
- **Florida** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. Protections do not apply for non-emergency services if covered individual has the ability and opportunity to choose an in-network provider who is available. State provides minimum payment standards, however for HMOs, the state payment standard only applies to emergency services. There is a dispute resolution process.
- **Georgia** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. The Protections do not apply if covered individual consents orally and in writing to using out-of-network provider and is provided an estimate of the charges in

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advance. The state provides a payment standard for professionals but not facilities and provides a dispute resolution process.

- **Illinois –** The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. Applies to 1) emergency services and 2) non-emergency services at in-network facilities. The Protections attach when the covered individual assigns the benefit to the provider. The protections only apply to services provided by facility-based providers defined as physicians or other providers who provide radiology, anesthesiology, pathology, neonatology or emergency department services. The State provides a dispute resolution process which can be initiated by the insurer or provider, after a negotiation period, by filing a request with the Department of Insurance.
- **Maine** – The State requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. Self-funded plans are allowed to opt into the protections for covered individuals, but only for emergency services. Covered individuals in self-funded plans that have not opted into the protections can pursue dispute resolution for emergency services, but the plan is not bound by the process. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. The Protections do not apply if covered individual voluntarily uses out-of-network provider. The state provides minimum payment standards. There is also an Independent Dispute Resolution process, but only for emergency services. Insurers are required to reimburse ambulance services at the insurers out-of-network rate, but this provision sunsets in October 2021. There is a state committee looking at the issue relating to ambulance services.
- **Maryland** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. Balance billing protections attach when a covered individual assigns the benefit. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. For HMO covered individuals, the protections apply to services provided by all types of out-of-network health care professionals. For PPO covered individuals, the protections apply to services provided by on-call or hospital-based physicians who agree to accept assignment of benefits. Protections do not apply if covered individual voluntarily uses out-of-network provider. The state provides minimum payment standards; however, the state has an all-payer rate setting system for hospital-based services governed by the Health Services Cost Review Commission (HSCRC)
- **Michigan** – The state prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. State provides minimum payment standards. An out-of-network provider can request binding arbitration with respect to emergency services under certain circumstances. The protections do not apply to non-emergency services when the covered individual consents in writing unless the covered individual does not have the ability to choose an in-network provider or is admitted. In obtaining consent, documents must be provided in accordance with certain timeframes. through the emergency room.
- **New Hampshire** – The state prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services at an in-network hospital and 2) non-emergency services at in-network facilities. The protections apply to any major medical product, including HMO, PPO, EPO and POS products. Protections only apply to providers

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performing anesthesiology, radiology, emergency medicine or pathology services. The state provides a dispute resolution process.

- **New Jersey** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. Protections apply to HMO, PPO, EPO and POS products and apply to any self-funded plan that has opted into the protections. The Protections do not apply for non-emergency services when in-network services are available in that facility and the covered individual signs a consent form agreeing to the services provided by the out-of-network provider. The state provides a binding arbitration process after a negotiation period.
- **New Mexico** – The State requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. The Protections do not apply for non-emergency services when in-network services are available in that facility and the covered individual signs a consent form agreeing to the services provided by the out-of-network provider. The state provides minimum payment standards. The state also sets rates for ambulance services.
- **New York** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. The balance billing protections attach when an covered individual assigns the benefit. It applies to 1) emergency services 2) non-emergency services at in-network facilities and 3) ground ambulance services except for inter-facility transportation. Certain hospitals in low-income areas are excluded. The protections do not apply for non-emergency services when in-network services are available in that facility and the covered individual signs a consent form agreeing to the services provided by the out-of-network provider. The state provides a dispute resolution process. Covered individuals in self-funded plans can directly initiate the dispute resolution process and the provider is bound by the decision, but the plan is not.
- **Ohio** – The state prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services 2) non-emergency services at in-network facilities and 3) ground ambulance services. The Protections do not apply for non-emergency services when in-network services are available in that facility, the covered individual is provided with a good faith estimate of the cost of a services and a disclosure that the covered individual is not required to obtain services at that location and the covered individual signs a consent form agreeing to the services provided by the out-of-network provider. The state provides a payment standard and dispute resolution process after a negotiation period.
- **Oregon** – The state prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services at an in-network hospital and 2) non-emergency services at in-network facilities. The Protections do not apply for non-emergency services when the covered individual has a reasonable alternative is informed of the reasonable alternative, informed of the out-of-pocket cost of the out-of-network service, and the covered individual signs a consent form agreeing to the services provided by the out-of-network provider. The state provides minimum payment standards.
- **Texas** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any

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amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. The protections do not apply for non-emergency services if the covered individual has a meaningful choice, is not coerced by policies such as cancellation fees and the covered individual sign an informed consent agreeing to the services provided by the out-of-network provider 10 days prior to the service. The state provides a dispute resolution process in the form of binding arbitration for most providers and non-binding mediation for emergency services, and out-of-network laboratory or diagnostic imaging services.

- **Virginia** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to self-funded plans that have opted into the protections in addition to HMO and PPO covered individuals. It applies to 1) emergency services and 2) non-emergency surgical or ancillary services at in-network facilities. With respect to non-emergency services, protections only apply to services provided by facility-based providers limited to surgical, radiology, anesthesiology, pathology, laboratory or hospitalist services. The state provides a payment standard requiring reimbursement to be a commercially reasonable amount based on the same or similar services provided in a similar geographic area. The state also provides a dispute resolution process which can be initiated by the provider.
- **Washington** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. Applies to 1) emergency services and 2) non-emergency surgical or ancillary services at in-network facilities. With respect to non-emergency services, protections only apply to services provided by facility-based providers limited to surgical, radiology, anesthesiology, pathology, laboratory or hospitalist services. It applies to self-funded plans that have opted into the protections as well as HMO and PPO covered individuals. The state also provides a dispute resolution process which appears to be non-binding, and which can be initiated by either the insurer or the provider.

States with Partial Protections

- **Arizona** – The State requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. Applies to 1) emergency services at in-network facilities and 2) non-emergency services at in-network facilities. Providers are not prohibited from balance billing PPO members. In cases where the dispute resolution process is used, a balance bill cannot be submitted where the arbitrator has made a decision. The Protections apply only to health plans that cover out-of-network care. A covered individual may consent to balance billing of non-emergency services, provided a disclosure is given to the covered individual a reasonable amount of time before services are rendered. The disclosure must inform the covered individual of the providers out-of-network status, a cost estimate, and a notice that the covered individual is not required to sign to obtain care, but if they do sign it, they waive rights to dispute resolution. The state provides minimum payment standards and a dispute resolution process for claims over $1,000 which must be initiated by the covered individual.
- **Delaware** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing for emergency services, including certain ground ambulance service providers, but does not ban balance billing for emergency services. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing for non-emergency services

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at in-network facilities. The protections do not apply to covered individuals who consent in writing to non-emergency services. There is a payment standard for emergency services and in the event the insurer and provider cannot agree, there is a dispute resolution process.

- **Indiana** – For HMOs, with respect to emergency services, the state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing for emergency services and prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. For HMOs and PPOs for non-emergency services at in-network facilities, out-of-network providers are prohibited from billing covered individuals for any amount beyond in-network cost sharing. This applies to all providers and so might protect covered individuals in self-funded plans. The protections do not apply to covered individuals who consent in writing to non-emergency services. A good faith estimate of costs must be provided at least 5 days prior to the scheduled services. There is a payment standard for emergency services and in the event the insurer and provider cannot agree, there is a dispute resolution process.
- **Iowa** – The state requires insurers to hold covered individuals harmless for amounts for emergency services at in-network facilities beyond in-network cost-sharing. Prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies only to emergency services. There are no protections for non-emergency services.
- **Massachusetts** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It applies to 1) emergency services at an in-network hospital and 2) non-emergency services at in-network facilities. The protections for emergency or non-emergency services do not apply if an in-network provider is available and the covered individual has a reasonable opportunity to choose to have the services performed by an in-network provider.
- **Minnesota** – The state requires insurers to hold covered individuals harmless for amounts for non-emergency services beyond in-network cost-sharing. There are no protections for emergency services. The protection does not apply if covered individual gives advance written consent to the provider acknowledging that the use of the out-of-network provider may result in costs not covered by the health plan. The state provides a dispute resolution process.
- **Mississippi** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies to 1) emergency services and 2) non-emergency services at in-network facilities. Balance billing protections attach when the covered individual assigns the benefit.
- **Missouri** – The state prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies only to emergency services provided at in-network facilities. There are no protections for non-emergency services. The state has a dispute resolution process.
- **Nebraska** – The state requires insurers to hold covered individuals harmless for amounts for emergency services beyond in-network cost-sharing. It prohibits out-of-network providers from billing covered individuals any amount beyond in-network cost-sharing. It applies only to emergency services. There are no protections for non-emergency services. The state has a minimum payment standard. The state has a dispute resolution process in the form of non-binding mediation.
- **Nevada** – The state requires insurers to hold covered individuals harmless for amounts for emergency services beyond in-network cost-sharing. Prohibits out-of-network providers from billing

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covered individuals any amount beyond in-network cost-sharing. It applies only to emergency services. There are no protections for non-emergency services. Self-funded plans can opt into the protections. The state has a minimum payment standard for a provider that recently had a network contract with the insurer. The state has a dispute resolution process.

- **North Carolina** – The state requires insurers to hold covered individuals harmless for amounts for emergency services provided by health care professionals beyond in-network cost-sharing. It applies only to emergency services provided by health care professional and does not apply to out-of-network facilities. There are no protections for non-emergency services.
- **Pennsylvania** – The state requires insurers to hold covered individuals harmless for amounts for emergency services provided by health care professionals beyond in-network cost-sharing for HMOs and PPOs that require gatekeepers. It applies only to emergency services provided by health care professional to HMOs sand to PPOs with gatekeepers and does not apply to out-of-network facilities. There are no protections for non-emergency services.
- **Rhode Island** – The state requires insurers to hold covered individuals harmless for amounts beyond in-network cost-sharing. The protections only apply when services are provided or made available to enrolled participants by a licensed health maintenance organization. It applies to 1) emergency services and 2) non-emergency services at in-network facilities.
- **Vermont** – The state requires insurers to hold covered individuals harmless for amounts for emergency services provided by health care professionals beyond in-network cost-sharing including ground ambulance services. It applies only to emergency services provided by health care professionals and does not apply to out-of-network facilities. There are no protections for non-emergency services.
- **West Virginia** – The state requires insurers to hold HMO covered individuals harmless for amounts for emergency services provided by health care professionals beyond in-network cost-sharing including ground ambulance services. It applies only to emergency services provided by health care professionals and does not apply to out-of-network facilities. There are no protections for non-emergency services.

States with No State Law

- **Alabama**
- **Alaska**
- **Arkansas**
- **Hawaii**
- **Idaho**
- **Kansas**
- **Kentucky**
- **Louisiana**
- **Montana**
- **North Dakota**
- **Oklahoma**
- **South Carolina**

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- **South Dakota**
- **Tennessee**
- **Utah**
- **Wisconsin**
- **Wyoming**

State Laws Covering All Payer Model Agreements

State law will be important in determining the cost-sharing amount (the "recognized amount") for the participant as well as the amount paid to the out-of-network provider (the "out-of-network rate"). State law will generally only apply to fully insured plans. The No Surprises Act will not preempt a state law unless the state law prevents the application of the No Surprises Act. Thus, states can impose requirements that are more restrictive than the No Surprises Act.

State law will not apply to self-funded health plans unless the plan has opted in to state law as allowed in a handful of states. A self-funded health plan that has chosen to opt in to a state law must do so for all items and services covered under the specific state law; prominently display in its materials describing the coverage of out-network services a statement that the plan has opted in to a specified state law, identify the state and provide a general description of the items and services covered by the state law.

In determining the cost-sharing amount of a participant for out-of-network charges subject to the No Surprises Act, the recognized amount is determined as follows:

1. An amount determined under an applicable All-Payer Model Agreement under Section 1115 of the Social Security Act;
2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
3. If there is no applicable All-Payer Model Agreement, then the lesser of the billed amount or the qualifying payment amount ("QPA").

As previously noted, items 1 and 2 above will not apply to self-funded plans unless the plan opted in to a state law. Also, items 1 and 2 will not be applicable to air ambulance claims because states are not allowed to regulate air traffic under the Airline Deregulation Act of 1978.

In order for either an All-Payer Model Agreement or a state law to be used in determining the recognized amount or out-of-network rate, the Agreement or state law must apply to coverage involved, to the out-of-network provider or facility and to the item or service involved. For example, assume a state law prohibited balance billing from certain providers under a fully insured plan, but did not include assistant surgeons in such law. In a case where an assistant surgeon provided non-emergency services at an in-network hospital, the state law would be inapplicable and the federal No Surprises Act would apply. It is possible that a claim could be determined in part by state law and in part by the No Surprises Act.

The out-of-network rate is determined as follows:

1. An amount determined under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act;

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2. If the is no applicable All-Payer Model Agreement, an amount determined under a specified state law; or

3. If there is no applicable All-Payer Model Agreement or applicable state law, then an amount agreed upon by the plan or issuer and the provider; or

4. If none of these three conditions apply, then either party may request the Independent Dispute Resolution ("IDR").

An All-Payer Model Agreement is an agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of all-payer payment reform for the residents of a state. Under the interim final rule, such Model Agreement is treated as applicable to a given provider or facility or plan if the terms of the Agreement are binding on the provider, facility or plan. For example, the All-Payer Model Agreement in Vermont is voluntary. If a plan opts in to the Agreement, but a specific provider does not opt-in, then the Agreement cannot be used in determining the recognized amount or out-of-network rate for any services involving that provider.

Following this explanation are two exhibits. The first exhibit lists the states that have All-Payer Model Agreements. The second exhibit lists the various applicable laws for each state with respect to prohibitions on balance billing and related items.

CAVEAT: The information on All-Payer Model Agreements and state laws are from early 2021. It is anticipated that this area will be undergoing changes for several reasons.

1. Several states have expressed strong interest in establishing an All-Payer Model Agreement;

2. he No Surprises Act provides funding for states to establish or expand All-Payer Model Agreements; and

3. States may change their laws in order to achieve better coordination with the No Surprises Act

Therefore, it is imperative to monitor state law on a continuous basis, so that the most current versions are taken into account.

All Payer Model Agreements

The following is a list of states that have All-Payer Model Agreements. The list reflects the status in early 2021, so it is important to monitor for changes. Most of the Agreements have been mandated by state legislation, but Oklahoma, Michigan, South Carolina, and Wisconsin are voluntary efforts not mandated by statute. Missouri is voluntary, but part of the Midwest Health Initiative which is regional.

- **Arkansas**
- **California**
- **Colorado**
- **Connecticut**
- **Delaware**
- **Florida**
- **Kansas**
- **Maine**

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- **Maryland**
- **Massachusetts**
- **Michigan**
- **Minnesota**
- **Missouri**
- **New Hampshire**
- **New York**
- **Oklahoma**
- **Oregon**
- **Rhode Island**
- **South Carolina**
- **Utah**
- **Vermont**
- **Virginia**
- **Washington**
- **Wisconsin**

In Implementation, these states either recently started to implement the All-Payer Model Agreement or have an effective date in the second half of 2021:

- **Georgia**
- **Hawaii**
- **Indiana**
- **New Mexico**
- **Nevada**
- **Texas**
- **West Virginia**

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Exhibit 8: Sample Language – Sample Plan Document Provisions

The language below can be modified as necessary and used to amend Plan Documents to reflect the requirements of the No Surprises Act to prevent surprise bills from Out-of-network providers providing services at In-network facilities:

"For Plan Years beginning on or after January 1, 2022, non-emergency services provided by an out-of-network provider during a visit at an in-network facility shall be paid as in-network and, the non-emergency services provider shall be required to hold a Participant harmless for amounts beyond the in-network cost-sharing requirement unless the out-of-network provider gives the participant notice and obtains the participant's prior consent.

To meet the notice and consent exception the out-of-network provider must give the participant:

- Written or electronic notice of the provider's out-of-network status,
- A list of in-network providers that the covered individual could see instead, and
- A good faith estimate of the participant charges at least 72 hours prior to furnishing the out-of-network services.

However, if the services are scheduled less than 72 hours in advance, then the Participant must be provided the notice no later than 3 hours before the services are furnished.

The Participant must sign a consent to receive the services from the out-of-network provider and acknowledge that he or she received the written or electronic notice.

A notice and consent exception exists for all ancillary services or items, or services furnished as a result of unforeseen, urgent medical needs that arise after the participant consented to the out-of-network non-emergency care at an in-network facility. These services are subject to the surprise and balance billing prohibitions applicable to emergency services provided by out-of-network health care providers.

The notice and consent exception does not apply to any items and services provided by an out-of-network provider when there was no alternative in-network provider at the facility who could furnish the covered item or service. Such services are considered to be "ancillary services." Other services considered to be "ancillary services," and thus always subject to the billing prohibitions by out-of-network providers of amounts beyond the in-network cost-sharing requirement, include:

- services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner).
- items and services provided by assistant surgeons, hospitalists, and intensivists.
- diagnostic services, including radiology and laboratory services; and
- items and services provided by certain specialty practitioners (which will be specified through future rulemaking).

The total amount paid by the Plan to the provider or facility, including any cost-sharing, to (in order of priority) is limited to:

- an amount determined by an applicable All-Payer Model (APM) Agreement, or
- an amount determined by specified state law, or
- an amount agreed upon by the plan/issuer and provider/facility, or (if none apply)
- an amount determined by an Independent Dispute Resolution (IDR) entity

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For services and items furnished by out-of-network providers where there is no state law determining the payment rate, then the out-of-network provider and the Plan will enter open negotiations regarding the out-of-network rate to be paid for the claim. If after the 30-day open negotiation period commences no agreement is reached, then either the plan or the health care provider can request that the claim be sent to the Independent Dispute Resolution (IDR) process to resolve the difference. The IDR process is operated by a certified IDR entity which shall determine the amount to be paid in accordance with the Consolidated Appropriations Act."

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Exhibit 9: Sample Language – Summary Plan Description Provisions

The language below can be modified as necessary and used to amend Summary Plan Descriptions to reflect the requirements of the No Surprises Act to prevent surprise bills from Out-of-network providers providing services at In-network facilities:

"Any non-emergency services provided by an out-of-network provider during your visit at an in-network facility shall be paid as in-network and, the non-emergency services provider shall be required to hold you harmless for amounts beyond the in-network cost-sharing requirement unless the out-of-network provider gives you notice and obtains your prior consent.

To meet the notice and consent exception the out-of-network provider must give you:

- written or electronic notice of the provider's out-of-network status,
- a list of in-network providers that the covered individual could see instead, and
- a good faith estimate of your charges at least 72 hours prior to furnishing the out-of-network services.

However. if the services are scheduled less than 72 hours in advance, then you must be given the notice no later than 3 hours before the services are furnished

You must sign a consent to receive the services from the out-of-network provider and acknowledge that you received the written or electronic notice.

Please remember that this notice and consent exception exists for all ancillary services or items, or services furnished to you as a result of unforeseen, urgent medical needs that arise after you consented to the out-of-network non-emergency care at an in-network facility. These services are subject to the surprise and balance billing prohibitions applicable to emergency services provided by out-of-network health care providers.

The notice and consent exception does not apply to any items and services provided to you by an out-of-network provider when there was no alternative in-network provider at the facility who could furnish the covered item or service. Such services are considered to be "ancillary services." Other services considered to be "ancillary services," and thus always subject to the billing prohibitions by out-of-network providers of amounts beyond the in-network cost-sharing requirement, include:

- services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner).
- items and services provided by assistant surgeons, hospitalists, and intensivists.
- diagnostic services, including radiology and laboratory services; and
- items and services provided by certain specialty practitioners (which will be specified through future rulemaking)."

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Exhibit 10: Sample Language – Administrative Services Agreement Provisions

The language below can be modified as necessary and used to amend Administrative Services Agreements to reflect the requirements of the No Surprises Act to prevent surprise bills from Out-of-network providers providing services at In-network facilities:

"For plan years beginning on or after January 1, 2022, the Claims Administrator shall pay non-emergency services provided by an out-of-network provider during a visit at an in-network facility as in-network and, the non-emergency services provider shall be required to hold a Participant harmless for amounts beyond the in-network cost-sharing requirement unless the out-of-network provider gives the participant notice and obtains the participant's prior consent. The Claims Administrator shall follow-up with the participant to determine if such notice is provided and meets the requirements provided below

To meet the notice and consent exception the out-of-network provider must give the participant:

- written or electronic notice of the provider's out-of-network status,
- a list of in-network providers that the covered individual could see instead, and
- a good faith estimates of the Participant of charges at least 72 hours prior to furnishing the out-of-network services.

However. if the services are scheduled less than 72 hours in advance, then the Participant must be provided the notice no later than 3 hours before the services are furnished.

The Claims Administrator must make sure that the Participant signs a consent to receive the services from the out-of-network provider and acknowledge in a timely manner that he or she received the written or electronic notice.

The Claims Administrator must advise participants that the notice and consent exception exist for all ancillary services or items, or services furnished as a result of unforeseen, urgent medical needs that arise after the participant consented to the out-of-network non-emergency care at an in-network facility. These services are subject to the surprise and balance billing prohibitions applicable to emergency services provided by out-of-network health care providers.

The Claims Administrator shall further advise participants that the notice and consent exception does not apply to any items and services provided by an out-of-network provider when there was no alternative in-network provider at the facility who could furnish the covered item or service. Such services are considered to be "ancillary services." Other services considered to be "ancillary services," and thus always subject to the billing prohibitions by out-of-network providers of amounts beyond the in-network cost-sharing requirement, include:

- services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner).
- items and services provided by assistant surgeons, hospitalists, and intensivists.
- diagnostic services, including radiology and laboratory services; and
- items and services provided by certain specialty practitioners. The Claims Administrator shall either initially pay the claim within 30 days of submission of a clean claim by the health care provider or issue a notice of denial of payment. The Claims Administrator shall monitor when the emergency claim was received, and when the initial and final payments are due, in addition to the ERISA claim and appeal timing deadlines.

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In determining the total amount to be paid by the Plan to the provider or facility, including any cost-sharing, to the Claims Administrator limited to (in order of priority):

- an amount determined by an applicable All-Payer Model (APM) Agreement, or
- an amount determined by specified state law, or
- an amount agreed upon by the plan/issuer and provider/facility, or (if none apply)
- an amount determined by an Independent Dispute Resolution (IDR) entity.

The Claims Administrator shall pay for services and items furnished by out-of-network providers where there is no state law determining the payment rate, then the out-of-network provider and the Claims Administrator will Plan will enter open negotiations regarding the out-of-network rate to be paid for the claim. If after the 30-day open negotiation period commences no agreement is reached, then either the plan or the health care provider can request that the claim be sent to the Independent Dispute Resolution (IDR) process to resolve the difference. The IDR process is operated by a certified IDR entity which shall determine the amount to be paid in accordance with the Consolidated Appropriations Act."

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Exhibit 11: Sample Language – Prevention of Surprise Bills for Air Ambulance Services – Plan Document Provisions

The language below can be modified as necessary and used to amend Plan Documents to reflect the requirements of the No Surprises Act to prevent surprise bills for Air Ambulance Services:

"If the Plan covers in-network air ambulance services, amounts paid for air ambulance services will now be treated as in-network for calculating reimbursement as determined under methodology set forth in the No Surprises Act and applicable regulations, and those amounts paid will be applied to the participant's deductible and OOPM under the Plan. Air ambulance providers shall not be able to balance bill participants for the remaining amounts. The Plan will provide detailed reports on air ambulance claims to the federal government.

Claims from an out-of-network air ambulance claim must count against the in-network deductibles and cost-sharing limits for the participant. The claim must initially either be paid or denied within 30 days of receipt after a clean claim is submitted.

The total amount paid by the Plan, including any cost-sharing, to (in order of priority) is limited to:

- an amount agreed upon by the plan/issuer and provider/facility, or (if none apply)
- an amount determined by an Independent Dispute Resolution (IDR) entity

For services and items furnished by out-of-network providers then the out-of-network provider and the Plan may enter Plan will enter open negotiations regarding the out-of-network rate to be paid for the claim. If after the 30-day open negotiation period commences no agreement is reached, then either the plan or the health care provider can request that the claim be sent to the Independent Dispute Resolution (IDR) process to resolve the difference. The IDR process is operated by a certified IDR entity which shall determine the amount to be paid in accordance with the Consolidated Appropriations Act.

The Claim Administrator shall monitor the date on which such emergency claim was received and when the initial and final payments are due in addition to the ERISA claim and appeal timing deadlines.

Participants or beneficiaries receiving air ambulance services which are paid for by the Plan for plan years beginning on or after January 1, 2022, should not be held liable for any amount in excess of their cost-sharing limits under the Plan (deductible, out-of-pocket maximum, co-insurance, or copayments) from an out-of-network air ambulance service provider.

The Plan shall report specific data regarding air ambulance use to the Secretaries of HHS, Labor, and Treasury for two years after the final regulations implementing the air ambulance provisions of the Act. The information includes claims data for each air ambulance use disaggregated by five factors."

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Exhibit 12: Sample Language – Prevention of Surprise Bills for Air Ambulance Services – Summary Plan Description Provisions

The language below can be modified as necessary and used to amend Summary Plan Descriptions to reflect the requirements of the No Surprises Act to prevent surprise bills for Air Ambulance Services:

"If the Plan covers in-network air ambulance services, then you will be required to pay the in-network cost-sharing amount for an air ambulance, and those amounts paid will be applied to your deductible and OOPM under the Plan. Air ambulance providers shall not be able to balance bill you for the remaining amounts.

Claims from an out-of-network air ambulance claim will count against your in-network deductibles and out of pocket maximum as provided by the Plan

Claim Administrator shall monitor the date on which such emergency claim was received and when the initial and final payments are due.

You and your dependents receiving air ambulance services which are paid for by the Plan, should not be held liable for any amount in excess of their cost-sharing limits under the Plan (deductible, out-of-pocket maximum, co-insurance, or copayments) from an out-of-network air ambulance service provider.

These provisions do not apply to ground ambulance services."

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Exhibit 13: Sample Language – Prevention of Surprise Bills for Air Ambulance Services – Administrative Services Agreement Provisions

The language below can be modified as necessary and used to amend Summary Plan Descriptions to reflect the requirements of the No Surprises Act to prevent surprise bills for Air Ambulance Services:

"Participants shall pay the in-network cost-sharing amount for an air ambulance service as determined under the No Surprises Act and applicable regulations and those amounts will be counted towards the Participant's deductible and OOPM under the Plan. The Claims Administrator will ensure that air ambulance providers shall not balance bill participants for any remaining amounts.

The Claims Administrator shall assist the Plan to provide detailed reports on air ambulance claims to the federal government.

The Claims Administrator shall apply claims from an out-of-network air ambulance claim against the in-network deductibles and cost-sharing limits for the participant. The claim must initially either be paid or denied within 30 days of receipt after a clean claim is submitted.

For purposes of this agreement, a "clean claim" is defined to be **[Definition of a clean claim]**.

In determining the total amount to be paid by the Plan to the provider or facility, including any cost-sharing, the Claims Administrator shall pay (in order of priority) the following:

- an amount agreed upon by the plan/issuer and provider/facility, or (if none apply)
- an amount determined by an Independent Dispute Resolution (IDR) entity

After the initial payment or denial, the Claims Administrator shall assist the Plan and the air ambulance provider to enter open negotiations regarding the out-of-network rate to be paid for the claim. If after the 30-day open negotiation period commences no agreement is reached, then either the Plan or the health care provider can request that the claim be sent to the Independent Dispute Resolution (IDR) process to resolve the difference, as provided in **[Applicable section of the administrative services agreement]**.

Claim Administrator shall monitor the date on which such emergency claim was received and when the initial and final payments are due in addition to the ERISA claim and appeal timing deadlines.

The Claims Administrator must make sure that Participants or beneficiaries receiving air ambulance services paid for by the Plan for plan years beginning on or after January 1, 2022, should not be held liable for any amount in excess of their cost-sharing limits under the Plan (deductible, out-of-pocket maximum, co-insurance, or copayments) from an out-of-network air ambulance service provider.

The Claims Administrator shall assist the Plan to report specific data regarding air ambulance use to the Secretaries of HHS, Labor, and Treasury for two years after the final regulations implementing the air ambulance provisions of the Act. The information includes claims data for each air ambulance use disaggregated by five factors."

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Exhibit 17: Sample Language – Choice of Health Care Provider – Plan Document Provisions

The language below can be modified as necessary and used to amend the Plan Document to reflect the requirements regarding the Choice of Healthcare Provider:

"If the plan requires or provides for Primary Care Provider (PCP) designation, Participants may choose their own PCP provided the PCP is in-network and available to accept new patients.

The Plan must allow direct access to OBGYN care. An OBGYN is required to adhere to all policies and procedures around referrals and authorizations.

The Plan must allow a pediatrician to be selected as a PCP.

If the Plan requires a participant to have a primary care provider, each Participant may designate any participating primary care provider who is available to accept such individual.

For a child, the Participant may 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.

The Plan may not require authorization or referrals for coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The OBGYN must agree to adhere to the Plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services related to a treatment plan. An OBGYN may refer patients for care or request prior authorization for care similar to a PCP."

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Exhibit 18: Sample Language – Choice of Health Care Provider – Summary Plan Description Provisions

The language below can be modified as necessary and used to amend Summary Plan Descriptions to reflect the requirements for the Choice of Healthcare Provider:

"If the Plan requires or provides for Primary Care Provider (PCP) designation, you may choose their own PCP provided the PCP is in-network and available to accept new patients.

You must be allowed direct access to OBGYN care. An OBGYN is required to adhere to all policies and procedures around referrals and authorizations.

You must be allowed to select a pediatrician as a PCP.

If the Plan requires you to have a primary care provider, you may designate any participating primary care provider who is available to accept you.

For a child you covered under the Plan, you may 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

The Plan may not require authorization or referrals for coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The OBGYN must agree to adhere to the Plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services related to a treatment plan. An OBGYN may refer patients for care or request prior authorization for care similar to a PCP."

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Exhibit 19: Sample Language – Choice of Health Care Provider – Administrative Services Agreement Provisions

The language below can be modified as necessary and used to amend Administrative Services Agreement Provisions to reflect the requirements for the Choice of Healthcare Provider:

"When administering the Plan, Participants must be allowed to choose their own PCP provided the PCP is in-network and available to accept new patients.

Participants must be allowed direct access to OBGYN care. An OBGYN is required to adhere to all policies and procedures around referrals and authorizations.

Participants must be allowed to select a pediatrician as a PCP.

Each Participant may designate any participating primary care provider who is available to accept such individual.

For a child, Participants may 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.

In administering the Plan, authorization or referrals for coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology are not allowed. The OBGYN must agree to adhere to the Plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services related to a treatment plan. An OBGYN may refer patients for care or request prior authorization for care similar to a PCP."

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Exhibit 23: Sample Language – Continuity of Care – Plan Document Provisions

The language below can be modified as necessary and used to amend Plan Document Provisions to reflect the requirements for Continuity of Care:

"For the first Plan Year beginning on or after January 1, 2022, a participant qualifies for protection if he or she is a continuing care patient and is receiving care from an In-network provider for (1) a serious and complex condition, (2) a course of institutional or inpatient care from a provider or facility, (3) a nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery, (4) pregnancy and is undergoing a course of treatment for the pregnancy, or (5) a determined terminal illness and is receiving treatment for such illness from a provider or facility, and such provider or facility's contract to be a network provider terminates or expires for any reason other than fraud by such provider or facility, then the Plan is required to meet all of the following requirements:

- The Plan must notify each Participant who is a continuing care patient that he or she is protected for continuing care at the time the provider or facility's contract terminates and inform such Participant that it is his or her right to elect continued transitional care from such provider or facility.
- The Plan shall provide such an individual with an opportunity to notify the Plan or insurer of the individual's need for transitional care.
- The Plan must permit such Participant to elect to continue to have the 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 had the provider or facility's contract not terminated.
- Such transitional coverage shall continue beginning on the date such Participant receives notice of the contract termination and shall continue until the earlier of 90 days after the Participant's receipt of such notice, or the date such Participant is no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility. The health care provider caring for such Participant is required to accept payment from the Plan for services and items furnished to such Participant as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the Plan."

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Exhibit 24: Sample Language – Continuity of Care – Summary Plan Description Provisions

The language below can be modified as necessary and used to amend Summary Plan Description Provisions to reflect the requirements for the Choice of Healthcare Provider:

"You will qualify for protection if you are a continuing care patient and are receiving care from an In-network provider for (1) a serious and complex condition, (2) a course of institutional or inpatient care from a provider or facility, (3) a nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery, (4) pregnancy and is undergoing a course of treatment for the pregnancy, or (5) a determined terminal illness and is receiving treatment for such illness from a provider or facility, and such provider or facility's contract to be a network provider terminates or expires for any reason other than fraud by such provider or facility, then the Plan is required to meet all of the following requirements:

- The Plan must notify you if you are receiving continuing care that you will be protected for continuing care at the time the provider or facility's contract terminates and inform you that it is your right to elect continued transitional care from such provider or facility.
- The Plan shall provide you with an opportunity to notify the Plan or insurer of your need for transitional care.
- The Plan must permit you to elect to continue to have the 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 had the provider or facility's contract not terminated.
- Such transitional coverage shall continue beginning on the date that you receive notice of the contract termination and shall continue until the earlier of 90 days after your receipt of such notice, or the date you are no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility. The health care provider caring for you is required to accept payment from the Plan for services and items furnished to you as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the Plan."

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Exhibit 25: Sample Language – Continuity of Care – Administrative Services Agreement Provisions

"Effective **[Date]**, Claims Administrator shall reimburse participant who qualifies as a continuing care patient and is receiving care from an In-network Provider for (1) a serious and complex condition, (2) a course of institutional or inpatient care from a provider or facility, (3) a nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery, (4) pregnancy and is undergoing a course of treatment for the pregnancy, or (5) a determined terminal illness and is receiving treatment for such illness from a provider or facility, and such provider or facility's contract to be a network provider terminates or expires for any reason other than fraud by such provider or facility, then the Plan is required to meet all of the following requirements:

Claims Administrator must notify each Participant who is a continuing care patient that he or she is protected for continuing care at the time the provider or facility's contract terminates and inform such Participant that it is his or her right to elect continued transitional care from such provider or facility.

Claims Administrator shall provide such an individual with an opportunity to notify the Plan or insurer of the individual's need for transitional care.

The Claims Administrator must permit such Participant to elect to continue to have the 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 had the provider or facility's contract not terminated.

Such transitional coverage shall continue beginning on the date such Participant receives notice of the contract termination and shall continue until the earlier of 90 days after the Participant's receipt of such notice, or the date such Participant is no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility. The health care provider caring for such Participant is required to accept payment from the Plan for services and items furnished to such Participant as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the Plan."

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Exhibit 26: Sample Notice – Continuity of Care – Termination from the Network Notice

TERMINATION FROM THE NETWORK NOTICE

[Date]

From: **[Name of Plan, Claims Administrator, Insurer, or Network Manager]**

To: **[Name of Participant or Insured]**

Re TERMINATION OF **[Name of Network Provider or Facility]**

Under the Consolidated Appropriations Act, 2021 (CAA)., we are required to provide you with a notice when a Provider or Facility leaves the Plan's network while providing you with ongoing care.

As of **[Date]**, **[Name of Provider or Facility]** will be leaving the Plan's network.

What this means to you:

We are required to provide you transitional coverage for up to 90 days or until treatment ends (whichever is earlier) at in-network rates if you qualify as a continuing care patient. This transitional coverage may apply to **[Procedure Codes, Description of Care applicable]**.

If you wish to continue your care under this provision, please return the NOTICE FOR NEED FOR TRANSITIONAL CARE within **[Number of Days]** days of receipt of this notice to:

[Name of Plan, Claims Administrator, or Insurer]

[Address]

[City, State, Zip]

Contact Information:

If you have any questions, please contact **[Name of Contact]** at **[Telephone Number]**

When are you entitled to continuity of care?

You or your dependents will qualify for this protection and will be considered a Continuing Care Patient if your or your dependents are receiving care from a network provider for:

1. A serious and complex condition,
2. A course of institutional or inpatient care from a Provider or Facility,
3. A nonelective surgery from the Provider or Facility, including receipt of post-operative care with respect to a surgery,
4. Pregnancy and are undergoing a course of treatment for the pregnancy, or
5. A determined terminal illness and are receiving treatment for such illness from a Provider or Facility, and such Provider's or Facility's contract to be a network provider terminates or expires for any reason other than fraud by such Provider or Facility.

The **[Plan or Policy]** must permit you to elect to continue to have the benefits provided under the same terms and conditions as would have applied and with respect to such items and services as would have been covered had the Provider's or Facility's contract not terminated.

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Such transitional coverage shall continue beginning on the date you receive this notice and will continue until the earlier of 90 days after you receive this notice, or the date you or your dependent is no longer qualified as a continuing care patient under the definition above with respect to that Provider or Facility.

The Provider or Facility caring for you or your dependent is required to accept payment from the **[Plan or Policy]** for services and items furnished to you during the transitional coverage period as payment in full for such items and services and to maintain compliance with all policies, procedures, and quality standards imposed by the [Plan or Policy].

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Exhibit 27: Sample Notice – Continuity of Care – Notice for the Need of Transitional Care

NOTICE FOR THE NEED OF TRANSITIONAL CARE

As provided in the Summary Plan Description for **[Name of Plan]**, I **[Participant or Insured Name]** am providing a notice for the need of transitional care.

I qualify as a continuing care patient and am receiving care from an In-network provider for: (check all that apply):

- ☐ A serious and complex condition
- ☐ A course of institutional or inpatient care from a provider or facility
- ☐ A nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery
- ☐ Pregnancy and is undergoing a course of treatment for the pregnancy
- ☐ A determined terminal illness and is receiving treatment for such illness from a provider or facility

I have been informed by [Name of Provider or Facility] that their contract to be an in-network provider shall terminate or expires for any reason other than fraud by such provider or facility on **[Date]**.

I therefore request transitional coverage to begin on the date specified above (date of the Provider or Facility contract termination) and to continue until the earlier of 90 days after my receipt of such notice, or the date I am no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility.

I understand my cost-sharing liability will be limited to In-Network rates as determined under the No Surprises Act.

Name: **[Participant or Insured Name]**

Address: **[Participant or Insured Address]**

City: **[Participant or Insured City]** State: **[Participant or Insured State]** Zip Code: **[Participant or Insured Zip Code]**

I hereby acknowledge that the above information is true. I understand that my coverage can be terminated if any statement I make is not true.

[Participant or Insured Signature] **[Date]**

Signature Date

[Claims Administrator or Insurer Name] Acknowledgement:

I acknowledge that I received this form on **[Date]**

[Authorized Claims Administrator or Insurer Representative's Signature]

Signature

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Exhibit 28: Sample Form – Additional Disclosure Requirements – Health Plan Identification Card Contents

[Name of Plan or Policy]

[Name of Participant or Insured]

[Participant or Insured ID #]

Deductible **[Amount of Deductible]**

Out-of-pocket Maximum **[Amount of Out-of-pocket Maximum]**

[Information such as a telephone number, email, or website through which the Participant or Insured may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with the Plan, Claims Administrator, or Insurer and access additional information about applicable deductibles and maximum out-of-pocket limits.]

[A Quick Response (QR) code, Telephone Number, or Website URL] to access additional information about Deductibles, Out-of-pocket Maximums, or other Plan or Policy limits]

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Exhibit 29: Sample Form – Additional Disclosure Requirements – Advanced Explanation of Benefits (EOB)

ADVANCED EXPLANATION OF BENEFITS (EOB)

[Date]

To: **[Participant or Insured Name]**

From: **[Plan, Administrator, or Insurer Name]**

Re: **[Name of Provider or Facility]**, **[Item or Service Code, Name, and Description]**

You are receiving this Advanced Explanation of Benefits ("EOB") because we received a good faith estimate from a provider or facility indicated above. The plan is required by federal law to issue you this Advanced EOB before any medical services are furnished.

The above-named Provider or Facility is **[In-network or Out-of-network]** for that service. If In-network, then the contracted rate for the indicated service is **[Contracted Rate].**

If the above-named Provider or Facility is Out-of-network, you can receive information on In-network Providers or Facilities that could provide that service by contacting [Name of Contact, Email Address, and/or Telephone Number].

- The good faith estimate from the Provider or Facility for the Above-named Code is **[Amount of Estimate]**.
- A good faith estimate of the amount the Plan is responsible for (based on the good faith estimate submitted by the Plan or Facility) is **[Plan Responsibility Amount]**.
- A good faith estimate of your payment responsibility is **[Portion of the Provider or Facility good faith estimate for which the Participant or Insured is responsible].**
- A good faith estimate of the accrued amount already met by you toward the Deductible and Out-of-pocket Maximum as of the date of this Advanced EOB is **[Accumulated Out-of-pocket Amount]**.

The item or service **[is or is not]** subject to medical management (concurrent review, prior authorization or "fail-first protocols).

The above information is only an estimate based on the information supplied and may be subject to change.

[Any other information or disclaimers deemed appropriate by the health plan]

Important Information: Plan must issue an Advanced EOB Form within three business days of receiving a patient request or a notice of a scheduled service when the service is scheduled at least 10 business days after the notice. If the service is scheduled less than 10 days after the notice, the health plan must provide the Advanced EOB Form within one business day. This timeline may be modified if the service has low utilization or significant variation in costs.

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Exhibit 30: Compliance Tool – Price Comparison Tool for In-network Services Required

Action Plan and Checklist for Price Comparison Tool compliance

Date: **[Date]**

Health Plan: **[Health Plan Name]**

While regulations are not yet available, based on the written law and subsequent guidance, for plan or policy years beginning on or after January 1, 2023, a health plan is required to offer price comparison guidance by telephone and make available on its website a price comparison tool that (to the extent practicable) allows a covered individual, for the plan year, geographic region, and its participating providers, to compare the amount of cost sharing that the covered individual would be responsible for paying with respect to the furnishing of a specific item or service by any such provider.

Action Plan:

1. Determine if a Price Comparison Tool is currently available
2. Evaluate capabilities (see Capability Assessment) of existing Price Comparison Tools
3. Develop plan to close capability gaps
4. As necessary, develop request for proposal (RFP) to select a third party to maintain the Price Comparison Tool
5. Review contract language to ensure responsibilities are defined and disclaimer language is adequate
6. Communicate availability of the Price Comparison Tool

Factors to Consider in Building the Price Comparison Tool

When necessary, engage with legal counsel and other advisors as appropriate to negotiate with the vendor regarding establishing the internet website and populating it with the required data. The plan sponsor should attempt to obtain a contractually binding indemnification provision to protect the plan and plan sponsor in the event the vendor fails to meet its obligations under the contract.

Some important contractual elements to consider include:

- Where the site will be hosted?
- How access will be granted?
- What is the level of privacy and security measures in place?
- What restrictions are in place related to the use of search requests and results?
- How will the vendor host data on the site?
- What is the cost imposed by the vendor for its cooperation?
- How the contractually responsible party will satisfy the internet site's obligation to comply with federal requirements as to:
  - Accuracy of relevant information
  - Timeliness

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- Integration into plan design
- Data integration with other relevant plan vendors
- Search engine requirements

Capability Assessment

Identify the electronic posting requirements and actions needed to comply with the price comparison tool requirements. The necessary information is likely controlled by plan-related vendors. Therefore, the plan will need to negotiate with the appropriate party regarding the posting of that information.

Requirement	Current Capability	Necessary Modification	Responsible Party	Status
Price Comparison Tool Available				
Comprehensiveness of providers				
Type of provider, item or service included				
Geographic specific results				
Accuracy of relevant information				
Timeliness of information				
Integration into plan design to calculate cost sharing				
Real-time, individualized cost estimates of how much a covered person would pay for covered items or services				
Progress toward a deductible and out-of-pocket maximum				
Data integration with other relevant plan vendors				
Search engine requirements				
Ability to search by description or billing code				
Ability to search by the name of an in-network provider, all in-network providers, or for an out-of-network allowed amount or another rate that reflects how much the plan would pay				
The estimate that the plan generates will need to be based on in-network rates,				

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Requirement	Current Capability	Necessary Modification	Responsible Party	Status
out-of-network allowed amounts				

Sample Search will Include

- Provider Type
- Provider Name (optional)
- Type of Item or Service
  - Billing code, or
  - Description
- Zip Code

Sample Search Results will include

- Item or Service
- Procedure Code
- Description
- Plan Limits
- Remaining Deductible
- Remaining Out-of-Pocket Maximum

Provider Name and Location	Network Status	Contracted Rate	Estimated Participant Cost Share

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Exhibit 31: Compliance Tool – Provider Directories

Sample Search will Include

For each individual health care provider contracted to participate in any of the networks group health plan or health insurance coverage:

- Name
- Addresses
- Specialty
- Telephone Number(s)
- Digital Contact Information

For each medical group, clinic, or facility contracted to participate in any of the networks group health plan or health insurance coverage:

- Name
- Address
- Telephone Number(s)
- Digital Contact Information

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Exhibit 32: Sample Language – Removal of Gag Clauses – Sample Administrative Services Provisions

"For Plan Years beginning **[Date]** , the Plan cannot enter into any agreement with a provider, network of providers, or entity offering access to a network of providers if it would preclude the Plan from (a) disclosing provider-specific cost or quality-of-care information or data through a consumer-engagement tool or other means, to referring providers, the plan sponsor, or participants; (b) electronically accessing de-identified claims information (in accordance with HIPAA, GINA and the ADEA); and (c) sharing this information with a Business Associate. (Reasonable restrictions on public disclosure of the information will be permitted.) This provision will override any contrary existing provisions under state law."

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Exhibit 33: Sample Form – Direct and Indirect Compensation – Direct and Indirect Compensation Disclosure Form for GHP Related Compensation

(Note: This Form is only for contracts, renewals, or extensions on or after December 27, 2021)

DIRECT AND INDIRECT COMENSATION DISCLOSURE

Date: **[Date]**

From: **[Broker, Agent, Consultant or Other Service Provider Name]**

To: **[Name of Responsible Plan Fiduciary]**

[Health Plan or Insurance Policy Name]

For the period beginning: **[Date]**

[Broker, Agent, Consultant or Other Service Provider Name], to comply with the Consolidated Appropriations Act, 2021 (CAA) rules requiring brokers, agents, consultants, and other service providers to disclose direct and indirect compensation that those service providers receive to steer health plan sponsors to certain insurance carriers, benefits administrators, and other vendors, discloses the following:

- **[Broker, Agent, Consultant or Other Service Provider Name]** has provided the following services to **[Health Plan or Insurance Policy Name]** pursuant to the contract or arrangement between the two parties:

  [Description of services]

- **[Broker, Agent, Consultant or Other Service Provider Name]** (or an affiliate or subcontractor) **[will] [will not]** provide, or **[reasonably expects] [does not reasonably expect]** to provide, fiduciary services to the covered plan.
- **[Broker, Agent, Consultant or Other Service Provider Name]** reasonably expects to receive **[Description of all direct compensation the service provider (or an affiliate or subcontractor)]** in connection with the provision of services.
- **[Broker, Agent, Consultant or Other Service Provider Name]** [**reasonably expects] [does not reasonably expect]** to receive **[Description of all indirect compensation the service provider (or an affiliate or subcontractor) reasonably expects to receive in connection with the provision of services (including incentives paid to a brokerage firm not solely related to the contract with the covered plan)]**, for services provided in connection with **[Description of the arrangement between the payer of the indirect compensation and the recipient service provider; a description of the services for which the indirect compensation is received, and the identity of the payer of the indirect compensation]**.
- **[Broker, Agent, Consultant or Other Service Provider Name]** receives **[description of any and all compensation arrangements]** from **[Name of payer]** in the amount of **[amount of direct or indirect compensation including commissions, finder's fees, etc., with any necessary explanations of variations]**.
- Upon termination of the contract or arrangement with **[Health Plan or Insurance Policy Name], [Broker, Agent, Consultant or Other Service Provider Name]** will receive **[Description of any compensation that the service provider (or an affiliate or subcontractor) reasonably expects to receive in connection with termination of the contract or arrangement]**, and will return or refund

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[Description and/or amount of any prepaid amounts and how they are calculated] to **[Health Plan or Insurance Policy Name]** upon such termination.

- **[Broker, Agent, Consultant or Other Service Provider Name]** will be paid by **[Description of the manner in which any direct or indirect compensation will be received by the service provider (or an affiliate or subcontractor)]**.

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Exhibit 34: Sample Form – Direct and Indirect Compensation – Direct and Indirect Compensation Disclosure Form for Individual Insurance Related Compensation

This **Sample Form** will be developed at a later date.

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Exhibit 35: Sample Report – Direct and Indirect Compensation – Insurer Report to HHS

This **Sample Report** will be developed at a later date.

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Attachments

Attachment 1: Compliance Tool – CAA and Transparency Financial Impact Analysis Tool

CAA Transparency Financial Impact Analy

Attachment 2: Model Notice – "Model Disclosure Notice Regarding Patient Protections Against Surprise Billing"

CMS-10780 - Model Disclosure Notice Reg

Attachment 3: Model Notice and Model Form – "Standard Notice and Consent Documents Under the No Surprises Act"

CMS-10780 - Standard Notice and (

Attachment 4: Compliance Tool – "State Balance-Billing Protections"

Hoadley_state_balanc e_billing_protections_

Attachment 5: Model Compliance Tool – "Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)"

self-compliance-tool.pdf

Attachment 6: Model Compliance Tool – "Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance"

mhapeachecklistwarn ingsignscleared16286

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Attachment 7: Model Compliance Tool – "FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE CONSOLIDATED APPROPRIATIONS ACT, 2021 PART 45"

faqsaboutmentalheal
thandsubstanceusedis

Attachment 8: Model Compliance Tool – Fact Sheet FY 2020 MHPAEA Enforcement

fy2020mhpaeaenforc
ement162868733303

Attachment 9: Compliance Tool – MHPAEA Comparative Analysis Tool

CAA MHPEA
Comparative Analysis

Attachment 10: Compliance Tool – Prescription Drug Reporting Tool

Prescription Drug
Reporting Tool v1.xlst

Attachment 11: Model Compliance Tool – Supporting Statement for Paperwork Reduction Act 1995: Independent Dispute Resolution Process

SUPPORTING
STATEMENT FOR PAP

Attachment 12: Model Notice – Open Negotiation Notice

Open Negotiations
Notice.pdf

Attachment 13: Model Notice – Notice of IDR Initiation

Notice of IDR
Initiation.pdf

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Attachment 14: Model Compliance Tool – IFR Appendix 1 Selection of Certified IDR Entity Data Elements

IFR Appendix 1
Selection of Certified I

Attachment 15: Model Compliance Tool – IFR Appendix 2 Notice of Agreement Data Elements

IFR Appendix 2
Notice of Agreement I

Attachment 16: Model Compliance Tool – IFR Appendix 3 Notice of Offer Data Elements

IFR Appendix 3
Notice of Offer Data E

Attachment 17: Model Compliance Tool – IFR Appendix 4 Entity Certification Data Elements

IFR Appendix 4 Entity
Certification Data Elen

Attachment 18: Model Form – Petition to Deny or Revoke IDR Certification

Petition to Deny or
Revoke IDR Certificati

Attachment 19: Model Compliance Tool – IFR Appendix 5 Entity Reporting Data Elements

IFR Appendix 5 Entity
Reporting Data Eleme

Attachment 20: Model Form – Request for Extension of Federal IDR Process Time Periods Due to Extenuating Circumstances

Request for Extension
Due to Extenuating Ci

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Attachment 21: Model Compliance Tool – IFR Appendix 6 Certified IDR Entity's Written Decision of Payment Determination Data Elements

IFR Appendix 6
Certified IDR Entity's \

Attachment 22: Model Compliance Tool – Revenue Procedure 2022-11

revenue procedure
22-11.pdf

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Appendix

Contact Information

Please feel free to contact us if you have any questions or need any support.