

No Surprises Act Toolkit for Consumer Advocates

November 2023



Quick Start Guide

What is the No Surprises Act?

The No Surprises Act was signed into law on December 27, 2020. This law gives consumers new federal protections from surprise medical bills by prohibiting balance billing and limiting consumer cost sharing in certain circumstances where surprise billing has been common.

In general, the No Surprises Act protects consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage obtained through an employer, the Federal Employees Health Benefits Program, the Health Insurance Marketplace^{®1}, or an individual plan purchased directly from an insurance company.* The new surprise billing protections apply when these consumers receive:

- Most emergency services from out-of-network providers or out-of-network emergency facilities;
- Non-emergency services from out-of-network providers with respect to a patient's visit to certain types of in-network health care facilities; and
- Air ambulance services from out-of-network air ambulance service providers.

If consumers are uninsured or decide not to use their health insurance for a service, the new law enables them to get a good faith estimate of the expected cost of their care up front, before receiving the service. If consumers receive a bill significantly higher than the estimate, they may be able to dispute the charges through a new federal arbitration process.

The No Surprises Act also includes other new protections related to continuity of care, provider directories, health plan insurance cards, and more. Most No Surprises Act provisions went into effect on January 1, 2022, although some have not yet been implemented. See [No Surprises Act Protections: Status of Implementation](#).**

Who is this toolkit for?

This toolkit is designed for consumer advocates and others who help individuals resolve medical billing problems. It was created to support advocacy organizations that provide a range of services, including groups that:

- Educate the public about how to tackle medical debt;
- Operate help lines that screen consumer complaints and make referrals to government agencies; and
- Help consumers directly with their billing issues, such as legal assistance organizations.

*For a more complete list of the types of health coverage subject to the No Surprises Act, see [No Surprises Act: Overview of Key Consumer Protections](#). As noted above, the No Surprises Act protections generally apply to individuals who are covered by group health plans and group or individual health insurance coverage (including grandfathered health plans), and Federal Employees Health Benefits (FEHB) Program carriers. Throughout this toolkit, unless otherwise specified, terms such as "health insurance," "health plan," and "health coverage" are used interchangeably to refer to these coverage types. The term "health insurance issuer" (or "issuer") refers to an insurance company (including FEHB carriers) that offers group or individual health insurance coverage.

**This Consumer Advocate Toolkit provides information on many of the new consumer protections included in the No Surprises Act. Information on additional provisions of the law will be provided in the future.

¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

How can advocates use this toolkit?

Consumer advocates can use this toolkit when working directly with consumers who may be faced with surprise medical bills. The toolkit can help advocates identify whether a consumer may have protections under the No Surprises Act. It can also help them to:

- Understand the provisions of the No Surprises Act;
- Understand the interaction between federal and state surprise billing laws;
- Recognize new documents that consumers may receive from providers and health plans;
- Find additional assistance and help consumers file a surprise billing complaint; and
- Create and share informational materials with the public about the No Surprises Act's new protections.

What does the toolkit contain?

The toolkit provides the following information:

- Background information providing context about the U.S. health coverage system;
- Introductory information about who is covered by No Surprises Act protections;
- Fact sheets describing the No Surprises Act protections and status of implementation;
- Information about how the No Surprises Act interacts with state surprise billing laws;
- Sample documents that consumers may see as a result of the new law;
- Decision trees to help consumer advocates analyze a consumer's situation and whether they may have protections under the No Surprises Act;
- Fact sheets describing actions that can be taken to resolve instances of non-compliance with the federal law and how to work with the No Surprises Help Desk; and
- Reference materials, including legal citations and a glossary of key terms.

How is the toolkit organized?

The toolkit is comprised of fact sheets, decision trees, and sample documents that are designed to be used as standalone resources. They are grouped into the following sections:

- 1. No Surprises Act Consumer Protections**
- 2. Helping Consumers Who Receive Surprise Bills**
- 3. How to Take Action**
- 4. State Laws and the No Surprises Act**
- 5. Sample Documents**
- 6. Reference Materials**

For more information, visit <https://www.cms.gov/nosurprises>.

NOTE: Some documents may contain links to non-United States Government websites. These links are provided because they contain additional information relevant to the topic(s) discussed in a document or that otherwise may be useful to the reader. The U.S. Government cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. These links are provided for reference only; linking to a non-U.S. Government website does not constitute an endorsement by the U.S. Government or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by U.S. Government websites do not apply to third-party sites.

Table of Contents

Please click on the name of each resource to access it.

1. No Surprises Act Consumer Protections

No Surprises Act: Overview of Key Consumer Protections

Who Has Protections Under the No Surprises Act

No Surprises Act Protections: Status of Implementation

When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use
Health Insurance Basics

2. Helping Consumers Who Receive Surprise Bills

Key Words Related to Surprise Billing Protections

Decision Tree: No Surprises Act Federal Surprise Billing Protections

Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals

Decision Tree: Patient-Provider Dispute Resolution Process

Decision Tree: Notice and Consent

3. How to Take Action

Helping Consumers Protect Their Rights Under the No Surprises Act

No Surprises Act: How to Get Help and File a Complaint

Tips for Using the No Surprises Consumer Complaint Form

4. State Laws and the No Surprises Act

State Surprise Billing Laws and the No Surprises Act

Questions and Answers on the No Surprises Act and State Laws

5. Sample Documents

Sample Notice and Consent Form

Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Sample Good Faith Estimate Abbreviated Version

Sample Notice of Surprise Billing Protections

Sample Notice of Uninsured (or Self-Pay) Individual's Right to Receive a Good Faith Estimate

6. Reference Materials

No Surprises Act Consumer Advocate Toolkit Glossary

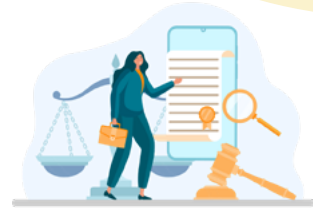
No Surprises Act Consumer Advocate Toolkit: Legal Citations

1. No Surprises Act Consumer Protections

[GO BACK TO TOC](#)



No Surprises Act Overview of Key Consumer Protections



This document is designed for consumer advocates and others to use when helping individuals with surprise medical bills. A recent federal law called the No Surprises Act went into effect in January 2022 and gave consumers new protections from surprise medical bills in certain circumstances.¹

Key protections under the No Surprises Act that consumer advocates need to understand to support consumers include the following, discussed in the sections of this document listed below:

- [Protections Against Surprise Billing](#)
 - [Surprise Billing Protections: At a Glance](#)
 - [Surprise Billing Protections: In Depth](#)
 - [Health Coverage Subject to the No Surprises Act](#)
 - [Calculating Cost Sharing Under the No Surprises Act](#)
 - [Surprise Bills for Emergency Services](#)
 - [Surprise Bills for Non-Emergency Services](#)
 - [Surprise Bills for Air Ambulance Services](#)
 - [Notice and Consent Exceptions](#)
 - [Examples](#)
- [Good Faith Estimates for Uninsured or Self-Pay Individuals and Patient-Provider Dispute Resolution](#)
- [No Surprises Act Expansion of External Review Rights](#)
- [Transparency on Health Insurance Cards](#)
- [Improving the Accuracy of Provider Directory Information](#)
- [Continuity of Care Protections](#)

Where can I go for help?

A No Surprises Help Desk is available for consumers if they receive a surprise bill. Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>. For more information on contacting the No Surprises Help Desk, see [No Surprises Act: How to Get Help and File a Complaint](#).

State Consumer Assistance Programs (CAPs) may also help with surprise billing questions. To see if your state has a CAP, please visit this [state listing](#).



¹ Throughout this document, the terms “patient” and “consumer” are used interchangeably.

Protections Against Surprise Billing

Surprises Billing Protections: At a Glance

Surprise billing is a type of [balance billing](#), which occurs when a provider bills a consumer for the portion of a bill that the consumer's health insurance plan or coverage doesn't cover. A surprise bill is an unexpected balance bill for certain types of out-of-network costs that aren't covered. Surprise billing can often happen when a person does not have the chance to select an in-network provider, such as during a medical emergency.

The No Surprises Act protects people who are covered under group health plans, group and individual health insurance coverage, and the Federal Employees Health Benefits (FEHB) program carriers from surprise medical bills when they receive:

- Most [emergency services](#).
- **Non-emergency items and services** from out-of-network providers with respect to patient visits to certain **in-network facilities**.²
- Services from out-of-network air ambulance service providers.

The No Surprises Act surprise billing protections generally **do not apply**:

- When **non-emergency** items or services are provided with respect to a patient visit to an **out-of-network** facility.
- In certain circumstances when a provider or facility is permitted to provide notice to a consumer (or their representative) and obtain the individual's consent to waive the surprise billing protections. (See [When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use](#).)
- When the items or services provided are **not** covered by the person's health plan or insurance.
- To ground ambulance services.



² For purposes of non-emergency services under regulations implementing the No Surprises Act, a health care facility is: (1) a hospital, as defined in section 1861(e) of the Social Security Act; (2) a hospital outpatient department; (3) a critical access hospital, as defined in section 1861(mm)(1) of the Social Security Act; or (4) an ambulatory surgical center, described in section 1833(i)(1)(A) of the Social Security Act. This toolkit uses the term "facility" to refer to such health care facilities.

Surprise Billing Protections: In Depth

The No Surprises Act created new protections against surprise billing. The No Surprises Act generally protects consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage through an employer, the Federal Employees Health Benefits program, the Health Insurance Marketplace³, or an individual health insurance plan purchased directly from an insurance company. (See next section for additional details.) When the No Surprises Act applies, it prohibits surprise billing and limits the cost sharing to the consumer for certain items and services.

The No Surprises Act **prohibits surprise bills** for:

- **Most emergency services**, including [post-stabilization services](#), from an out-of-network hospital or an independent, freestanding emergency department.⁴
- **Non-emergency services** from an **out-of-network provider** delivered as part of a patient's visit to certain types of participating health care facilities⁵ (unless the out-of-network provider provided a notice of waiver of rights under the No Surprises Act and received consent from the patient).
- Services from out-of-network providers of **air ambulance services**. (Note: Ground ambulance services are not covered by the No Surprises Act).



Although consumers cannot receive surprise bills in these instances, they still may have some cost-sharing responsibility when the No Surprises Act applies. [Cost-sharing](#) requirements are outlined in a consumer's health plan and could include unmet [deductibles](#) (an amount consumer owes before the health plan begins to pay), [copayments](#) (a flat dollar amount per item or service), or [coinsurance](#) (a percentage of the contracted rate for an item or service). **However, under the No Surprises Act, the consumer's cost-sharing requirements for out-of-network items or services cannot be greater than in-network cost-sharing requirements.**

³ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

⁴ The definition of "independent freestanding emergency department" is intended to include any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide emergency services, even if the facility is not licensed under the term "independent freestanding emergency department." Only urgent care centers that are licensed to provide emergency services and that are geographically separate and distinct from a hospital are considered freestanding emergency departments and covered by the No Surprises Act.

⁵ See Table 3 below for details on which health care facilities are covered within the non-emergency services portion of the No Surprises Act.

Health Coverage Subject to the No Surprises Act

The No Surprises Act protections apply to consumers enrolled in the following types of health coverage:⁶

- Employment-based group health plans (both [self-funded](#) and fully insured).
- Individual or group health insurance coverage purchased on or outside the federal or state-based Marketplaces.
- Non-federal governmental plans that are sponsored by state and local government employers (for example, a health plan through a school district).
- Certain church plans.⁷
- Health benefits plans offered through the Federal Employees Health Benefits (FEHB) program.⁸
- Student health insurance plans offered by colleges or universities.



The No Surprises Act Protections Do Not Apply:

To consumers who have coverage through (or receive services provided by) the following government programs. These programs generally have certain protections against balance billing:

- Medicare (including Medicare Advantage).
- Medicaid (including Medicaid managed care plans).
- Indian Health Service.
- Veterans Affairs Health Care.
- The insurance programs that make up TRICARE.

To balance billing for items and services covered by certain types of health plans or insurance coverage, including:

- Short-term, limited-duration insurance.
- Retiree-only plans.
- Account-based group health plans (such as health reimbursement arrangements or HRAs).
- Disease-specific plans, such as cancer-only policies.
- Hospital indemnity policies.
- Accident-only policies.
- Items and services covered by stand-alone vision or dental plans.

Note: If consumers have a major medical health plan that includes dental or vision benefits, these protections could apply to any dental or vision service covered by their health plan.

⁶ The provisions of the No Surprises Act that are applicable to group or individual health insurance coverage generally apply to grandfathered health plans.

⁷ “Church plans” do not include health care sharing ministries, which are generally not considered health insurance coverage.

⁸ Throughout this toolkit, the term “health plan” (or “plan”) generally also includes coverage under a health benefits plan offered through the FEHB program. The term “health insurance issuer” (or “issuer”) generally also includes FEHB insurance carriers. Additional explanation is provided in the toolkit introduction.

Calculating Cost Sharing Under the No Surprises Act

Under the No Surprises Act, the way that cost sharing is calculated differs from typical out-of-network cost-sharing calculations.⁹ The No Surprises Act requires cost sharing to be calculated using a “[recognized amount](#).” This amount can vary depending on whether an [All-Payer Model Agreement](#) or a state law applies in a particular circumstance (see Table 1 below).



Table 1: Three Ways to Determine the Recognized Amount When an Item or Service is Covered by the No Surprises Act*

The Recognized Amount Is:		
1. The amount that a state approves under an All-Payer Model Agreement	when	<ul style="list-style-type: none"> An item or service is covered by an All-Payer Model Agreement
2. The amount determined by state law	when	<ul style="list-style-type: none"> An All-Payer Model Agreement does not apply to determine cost sharing; and A state has an applicable law that addresses the amount payable for the item or service**
3. The amount that is the lesser of: <ul style="list-style-type: none"> The amount billed by the provider or facility; or The Qualifying Payment Amount for the item or service, which is generally based on the median contracted rate that a health plan pays to providers in the same geographic region 	when	<ul style="list-style-type: none"> A state law or All-Payer Model Agreement does not apply to determine the cost-sharing amount

* Cost-sharing amounts for out-of-network air ambulance services must be calculated using the lesser of the billed charge or the Qualifying Payment Amount.

** Specifically, a state must have a “specified state law,” which provides a method for determining the total amount payable under group or individual health coverage to an out-of-network provider.

To determine which calculation method should be used, consumer advocates will first need to identify if there is an All-Payer Model Agreement or state law in place covering the items and services received. For more information on where to research state laws, see [State Surprise Billing Laws and the No Surprises Act](#). If the items and services received by a consumer are not covered by an All-Payer Model Agreement nor by state law and are covered under the No Surprises Act, the recognized amount will be the lower of the billed amount or the Qualifying Payment Amount (the third method shown in Table 1 above).

⁹ When surprise billing protections do not apply, out-of-network cost sharing is often based on a health plan’s “usual and customary rate” for an item or service. In addition, the provider may be able to bill the consumer for the difference between the provider’s billed amount and what the health plan has paid.

Calculating Cost Sharing When the No Surprises Act Applies (Instead of a State Law or an All-Payer Model Agreement)



When the No Surprises Act applies (instead of a state law or All-Payer Model Agreement), a health plan or issuer must determine the Qualifying Payment Amount for the items and services received and compare it to the billed amount from the provider or facility.¹⁰ It must then use the lower of these two amounts to determine the consumer's financial responsibility, applying any applicable in-network cost-sharing requirements. Using this process, a health plan might apply the amount of the Qualifying Payment Amount (or billed amount, whichever is lower) towards an unmet deductible or multiply the Qualifying Payment Amount (or billed amount, whichever is lower) by an in-network coinsurance percentage, if applicable.

For example, if the billed amount from a provider is \$300 and the Qualifying Payment Amount is \$325, the consumer's cost-sharing would be based on \$300. If the consumer had fully met their deductible and their health plan required a 20% coinsurance for the item or service that was furnished, the consumer would owe 20% of \$300.

Under the No Surprises Act, a consumer's cost-sharing requirement cannot be greater than their health plan's in-network cost-sharing requirement.* This means that:

- If the item or service is subject to coinsurance and the health plan requires 20% coinsurance for an item or service furnished by an in-network provider and 30% coinsurance when the item or service is furnished by an out-of-network provider, the consumer would only be responsible for the 20% coinsurance; and
- If the consumer receives an item or service that requires a \$25 copay when furnished by an in-network provider and a \$35 copay when furnished by an out-of-network provider, the consumer would only be responsible for the \$25 in-network copay.

* This is true regardless of the state in which the items and services were received and any state laws or All-Payer Model Agreements that may apply.

¹⁰ Note that when the No Surprises Act and no state law nor All-Payer Model Agreement applies, the amount that a health plan pays an out-of-network provider may be determined through negotiation or dispute resolution. That process is separate from the process for determining consumer cost sharing.

Surprise Bills for Emergency Services

Under the No Surprises Act, surprise bills for most **emergency services** for an **emergency medical condition** are prohibited (see Table 2). In addition, when the No Surprises Act applies, the consumer’s cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the item or service was provided in-network. For example, a consumer’s costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

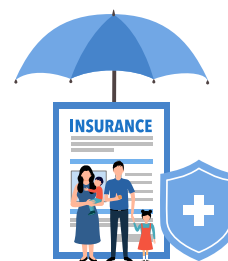
Table 2: Emergency Services, Facilities, and Providers Included in Surprise Billing Protections

Types of emergency services included	Facilities included	Types of health care providers included
<ul style="list-style-type: none"> • Medical screening exams, including ancillary services, to evaluate whether an emergency medical condition exists • Examination and treatment needed to stabilize the patient • Post-stabilization services (as part of outpatient observation or an inpatient or outpatient stay with respect to the visit for pre-stabilization emergency services)* 	<ul style="list-style-type: none"> • Hospital emergency departments (EDs) or emergency rooms (ERs) • Hospital departments caring for ER patients once stabilized • Independent, freestanding EDs that are separate from hospitals¹¹ • Urgent care centers that meet the definition of independent, freestanding emergency departments 	<ul style="list-style-type: none"> • Physicians • Physician assistants • Nurse practitioners • Other medical providers acting within their scope of practice under state law

* In limited circumstances, an out-of-network provider or emergency facility can use the No Surprises Act’s notice-and-consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for post-stabilization services. See description in the No Surprises Act Exceptions for Notice and Consent section below.

Under the No Surprises Act:

- If plans or issuers cover any emergency services, they must cover emergency services as defined in the regulations, even when provided at an out-of-network emergency facility.
- Health plans and health insurance issuers are prohibited from requiring prior authorization for emergency care and must determine whether a condition is an [emergency medical condition](#) based on an individual’s presenting symptoms and not on a final diagnosis code.
- Even when a person is treated at an in-network emergency department, the treating physician and other providers might be out-of-network. [Out-of-network](#) providers of emergency services may not bill more than the in-network cost sharing allowed based on the consumer’s plan or insurance coverage.
- Consumers cannot be balance billed for post-stabilization care unless they give consent to waive protections after receiving a written notice (in instances where consent is permitted).



¹¹ If under state licensure laws, a facility that provides behavioral health crisis response services is permitted to provide emergency services as described in 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-6(c)(2), and 45 CFR 149.110(c)(2), and is geographically separate and distinct from a hospital, then such a facility would fall within the definition of “independent freestanding emergency department” under the July 2021 Interim Final Rule, and the surprise billing protections would apply with respect to the emergency services provided with respect to a visit to the facility. See [FAQ Part 55 Question 10](#).

No Surprises Act

Overview of Key Consumer Protections

Prudent Layperson Standard of “Emergency Medical Condition”

Balance billing and out-of-network cost sharing aren’t allowed for emergency services when an individual gets care for an emergency medical condition, which is defined using a “prudent layperson” definition:

A person, who has typical knowledge of health and medicine, experiences a medical condition (including a mental health condition or substance use disorder) that is so severe they believe:

- They need immediate medical care; and
- Failing to get immediate medical care could:
 - Result in their health or the health of their unborn child being in serious jeopardy; or
 - Result in serious impairment to bodily functions; or
 - Lead to serious dysfunction of any bodily organ or part.



Surprise Bills for Non-Emergency Services

Under the No Surprises Act, surprise bills for **non-emergency services** are prohibited when these services are provided by **out-of-network providers with respect to a patient visit to an in-network health care facility**. (Table 3 below provides more details.)

In addition, when the No Surprises Act applies, the consumer’s cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the item or service was provided in-network. For example, a consumer’s costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

Table 3: Non-Emergency Services, Facilities, and Providers Included in Surprise Billing Protections

Participating health care facilities included	Examples of non-emergency items and services included*	Examples of out-of-network providers included
<ul style="list-style-type: none"> • Hospitals • Hospital outpatient departments • Ambulatory surgical centers • Critical access hospitals 	<ul style="list-style-type: none"> • In general, covered non-emergency services are subject to the No Surprises Act when delivered by an out-of-network provider as part of a patient’s visit to a participating health care facility. • Such services include but are not limited to: <ul style="list-style-type: none"> ○ Pre-operative and post-operative services ○ Equipment and devices ○ Telemedicine services • Ancillary services** (see box below) 	<ul style="list-style-type: none"> • Physicians • Physician assistants • Nurse practitioners • Assistant surgeons • Hospitalists • Intensivists • Anesthesiologists • Laboratories • Others acting within their scope of practice under state law

* These services don’t need to take place at the in-network facility to be considered part of a visit (for example, offsite laboratory services).

** Ancillary services provided at participating facilities, which individuals typically have little control over, are always subject to balance billing prohibitions. For a full definition of ancillary services under the No Surprises Act, see the [No Surprises Act Consumer Advocate Toolkit: Glossary](#).

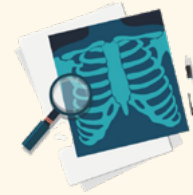
No Surprises Act

Overview of Key Consumer Protections

Ancillary Services

Ancillary services include items and services related to:

- Emergency medicine
- Anesthesiology
- Neonatology
- Pathology
- Radiology
- Diagnostic services, including radiology and laboratory services
- Items and services provided by assistant surgeons, hospitalists, intensivists
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at that facility.



Surprise Bills for Air Ambulance Services

Under the No Surprises Act, surprise bills are generally prohibited for covered **air ambulance services** provided by **out-of-network air ambulance providers**. In addition, when the No Surprises Act applies, the consumer's cost-sharing requirement for covered air ambulance services cannot be greater than the requirement that would apply if the services were provided in-network.

If a plan or issuer covers air ambulance services only for emergencies, the No Surprises Act does not require the plan or issuer to cover non-emergency air ambulance services or limit the amount a consumer may be charged for those non-emergency air ambulance services.

Table 4: Air Ambulance Services and Providers Included in Surprise Billing Protections.

Types of Service Included*	Providers Included
<ul style="list-style-type: none">• Medical transport by helicopter ("rotary wing" ambulance) and• Medical transport by airplane ("fixed wing" ambulance) <p>This applies to situations where air ambulance services are covered under the in-network terms of an individual's health plan/coverage, even if there are no in-network air ambulance service providers within an individual's plan/coverage.</p>	<p>Entities that are licensed under applicable state and Federal law to provide air ambulance services.</p>

* Note that the surprise billing protections for air ambulance services may apply even if the point of pickup is outside of the United States. For more information, see [FAQ Part 55 Question 8](#).

No Surprises Act Exceptions for Notice and Consent: Patients May *Explicitly Consent* to Waive Their Rights in Certain Circumstances

In limited situations, the No Surprises Act allows some out-of-network providers and facilities to seek written consent from individuals to voluntarily waive their protection against balance billing for 1) post-stabilization services and 2) non-ancillary, non-emergency services. These are referred to as notice and consent exceptions.

Providers must follow strict requirements for the process and timing of obtaining consent from consumers. This includes the requirement for providers to use the [Standard Notice and Consent](#) documents provided by the Centers for Medicare & Medicaid Services to secure consumer consent to waive No Surprises Act balance billing protections. (For a detailed description of the process, see [Decision Tree: Notice and Consent](#) and [When Notice and Consent Applies and When it Doesn't: Guidelines for Use](#).)

1. Use of the notice and consent exception is **only allowed** for post-stabilization services (following emergency services) if **all** the following requirements are met:

- ✓ An individual is stable enough to travel using nonmedical or non-emergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition;
- ✓ The individual or their authorized representative is in a condition where they can receive information and provide informed consent;
- ✓ The provider or facility provides written notice and obtains written consent from the individual to waive balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements; and
- ✓ The provider or facility complies with applicable state laws.

2. Use of the notice and consent exception is **only allowed** for non-emergency services if **all** of the following requirements are met:

- ✓ The items or services do not meet the definition of ancillary services;
- ✓ The items or services are not furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished;
- ✓ Another in-network provider can deliver the items or services at the in-network health care facility; and
- ✓ The provider gives written notice and gets written consent from the individual to waive the balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.



Before a consumer waives their balance billing and cost-sharing protections, the provider or facility must provide the individual with a good faith estimate of expected charges for the items and services that are reasonably expected to be provided.

No Surprises Act

Overview of Key Consumer Protections

Example: How Surprise Billing Protections Work for Emergency Services

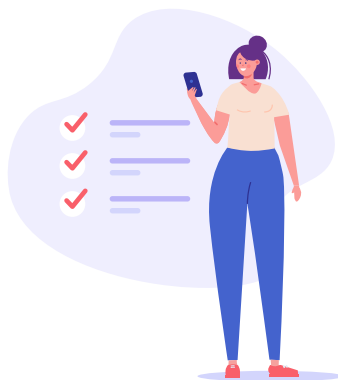
Zoe is a 26-year-old with Marketplace coverage. She has severe pain, swelling, and redness of her right calf. Using reasonable layperson judgment, she becomes concerned that this may be dangerous and may place her health in serious jeopardy. She goes to her local hospital's emergency department, which is in her health plan's network. She has a venous ultrasound (a type of imaging used for diagnosis). The radiologist, who is out-of-network, reads the ultrasound, which shows a deep vein thrombosis. Zoe is started on medication and discharged from the emergency department. A few weeks later, Zoe gets a surprise bill from the radiologist, asking her to pay the difference between the in-network rate for his services and the billed charges (out-of-network rate). She is confused because the hospital was in her health plan's network.



Per the No Surprises Act, the out-of-network radiologist cannot bill Zoe more than the cost-sharing amount determined by her plan consistent with the surprise billing protections.

What actions can Zoe take to resolve this issue?

- Zoe or her advocate can call the No Surprises Help Desk for assistance with handling this surprise bill. (See [No Surprises Act: How to Get Help and File a Complaint](#) for detailed information on how to file a complaint.)
- Zoe or her advocate can refer to [Helping Consumers Protect Their Rights under the No Surprises Act](#) for information on additional steps to enforce her rights under the No Surprises Act.
- If Zoe lives in a state with a [Consumer Assistance Program](#), Zoe or her advocate can reach out to seek help with a surprise bill for emergency care.



No Surprises Act Overview of Key Consumer Protections

Example: How Surprise Billing Protections Apply to Post-Stabilization Services



Carlos is a 62-year-old with employer-sponsored health coverage. He is involved in a ski accident and sustains multiple injuries. He is taken to the closest hospital emergency department, which is out-of-network. He undergoes surgery to repair multiple leg fractures.

Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the only safe form of transport, given his medical state, would be via ambulance. Carlos knows that the hospital he is in has an excellent reputation and he wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his surprise billing protections under the No Surprises Act. He remains an inpatient for two additional days and is ultimately discharged to home.

The No Surprises Act's prohibition on balance billing and out-of-network cost sharing for emergency services applies to all days of care Carlos received from this hospital.

- The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized, and he cannot be charged out-of-network cost sharing.
- The hospital is also banned from balance billing him for post-stabilization services provided after surgery, and he cannot be charged out-of-network cost sharing for those services, despite the hospital's obtaining written consent from Carlos to waive his surprise billing protections under the No Surprises Act. This is because he could only safely be transferred via ambulance, rather than using non-medical or non-emergency medical transport.
- The hospital's consent from him to waive his surprise billing protections under the No Surprises Act specific to post-stabilization services is not valid, and the prohibitions against balance billing continue to apply to the hospital. In the event that an individual requires medical transportation to travel, the individual is not in a condition to receive notice or provide consent.



No Surprises Act Overview of Key Consumer Protections

Example: How Notice and Consent Works in Emergency Settings

Sebastian is a 55-year-old with employer-based group coverage. One evening Sebastian experiences chest pain and, using reasonable layperson judgment, believes he may be experiencing the symptoms of a heart attack. He goes to the closest emergency department, which is part of a hospital that is in Sebastian's health plan network. At the hospital, he is evaluated by an emergency physician who is not a participating provider with Sebastian's health plan. The physician determines that Sebastian is having a heart attack. The out-of-network provider and hospital staff stabilize Sebastian and admit him as an inpatient for follow-up care.



Per the No Surprises Act, the out-of-network provider may not ask Sebastian to sign a notice and consent form to waive his surprise billing rights while he is receiving pre-stabilization emergency services (i.e., while he is being evaluated and stabilized). Once Sebastian is stabilized, out-of-network providers who treat Sebastian may ask him to sign a notice and consent form to waive his surprise billing protections for non-ancillary services **only** if specific conditions are met. (For additional details, see [Decision Tree: Notice and Consent](#).)

Note: If the hospital does not have any available treating providers who are in-network with Sebastian's health plan, then Sebastian cannot be asked to sign a consent to waive his surprise billing protections. In addition, providers and facilities may **never** seek an individual's consent to waive the No Surprises Act's surprise billing protections for non-emergency ancillary services or for unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Good Faith Estimates for Uninsured (or Self-Pay) Individuals and Patient-Provider Dispute Resolution

Beginning January 1, 2022, health care providers and facilities must provide an estimate of expected charges to individuals who do not have health coverage (or those who lack coverage for a particular item or service) and individuals who have certain health coverage but who are not seeking to have claims submitted to their insurance for items or services (also known as "self-pay" individuals). This estimate of charges is known as a "good faith estimate" (estimate).

The estimate also must include expected charges for items or services reasonably expected to be provided along with the primary item(s) or service(s). See: [Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act](#) for more information.

No Surprises Act Overview of Key Consumer Protections

If items or services are expected to be furnished by more than one provider or facility, the provider or facility who receives the initial request and who is (or in the case of a request, would be) responsible for scheduling the primary item or service will become the **convening provider**. The No Surprises Act requires good faith estimates from a convening provider to include any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by a **co-provider** or **co-facility**. However, CMS is not currently enforcing this requirement, pending future rulemaking.

If the actual bill for health care items or services from a provider or facility is at least \$400 higher than the estimate for that provider or facility, then the consumer may be able to challenge the bill using the Patient-Provider Dispute Resolution process. To learn more about the dispute resolution process, including eligibility requirements and what information or documents are needed to start a dispute, see [Dispute a medical bill](#).

Providers Who Must Comply with Requirements

All licensed or certified health care providers must comply with these requirements to provide estimates for uninsured (or self-pay) individuals and the dispute resolution process. Examples of providers include:

- Physicians
- Physician Assistants and Nurse Practitioners
- Providers of air ambulance services
- Other providers and practitioners acting within their scope of practice under state law



Facilities that Must Comply with Requirements

All licensed or certified health care facilities must comply with these requirements to provide estimates for uninsured (or self-pay) individuals and the dispute resolution process. Examples of facilities include:

- Hospitals
- Hospital outpatient departments
- Independent, freestanding emergency departments
- Critical access hospitals
- Ambulatory surgical centers
- Rural health clinics
- Federally Qualified Health Centers
- Laboratories and laboratory centers
- Imaging centers

Eligibility to Receive a Good Faith Estimate for an Uninsured (or Self-Pay) Individual

Providers and facilities must offer to provide a good faith estimate to all uninsured and self-pay individuals upon scheduling a health care item or service, or if the uninsured (or self-pay) individual requests an estimate, subject to certain timeframes. In addition, providers and facilities must treat any discussion or inquiry about the cost of items or services by an uninsured or self-pay consumer as a request for an estimate. The convening provider or facility must provide written notice of the right to receive a good faith estimate in a clear and understandable manner. The notice must also be prominently displayed (and easily searchable from a public search engine) on the convening provider's or convening facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur.

Determining Health Coverage or Insurance Status

Before providing an estimate, a provider or facility first must determine if a consumer who has contacted them about health care is uninsured or self-pay. To determine if an individual is uninsured or self-pay, the provider or facility must ask if the individual is enrolled in any of the following:

- A group health plan or group health insurance (such as through an employer or union).
- Individual coverage purchased through the Marketplace or directly from an insurance company.
- A federal health care program (such as Medicare (including Medicare Advantage), Medicaid (including Medicaid managed care plans), Veterans Affairs Health Care, or TRICARE);
- A health benefits plan offered through the Federal Employees Health Benefits (FEHB) program.

If the individual is **not** enrolled in any of the above (or is covered under a short-term, limited duration plan), the individual is considered uninsured for the purposes of the estimate.

If the individual has a group health plan or group health insurance, individual health insurance or FEHB coverage, the provider or facility must ask if the individual is seeking to have a claim submitted for items or services being scheduled or requested. If not, the individual is considered self-pay for the purposes of the estimate.



Required Information for Good Faith Estimates

A good faith estimate must include, among other information, expected charges for the main health care item or service the consumer is seeking. It must also include expected charges for any other items or services that will be provided within the same period of care for that health care item or service. In addition, a complete good faith estimate must include a disclaimer that the information is only an estimate of reasonably expected charges and that actual charges may differ.



- Note that individuals may qualify for a provider's or facility's sliding fee discounted price. These individuals may receive a complete good faith estimate with the undiscounted price for items and services if the provider or facility lacks current information to calculate the discounted prices. For additional information about good faith estimates when sliding scale discounts are offered, see [CMS FAQ Part 4](#) on good faith estimates.
- If a provider or facility does not expect to bill an individual for any items or services, the consumer may receive an **abbreviated** good faith estimate. An abbreviated good faith estimate does not list any items or services and must state the provider's commitment not to bill the consumer. For additional information on the requirements for an abbreviated good faith estimates see [CMS FAQ Part 4](#) on good faith estimates.

Sometimes the estimated costs can change—for example, if a provider listed on the estimate becomes unavailable. In that case, the convening provider or facility must provide a new estimate no later than one business day before the item or service is scheduled to be furnished. If any changes in expected providers or facilities represented in a good faith estimate occur less than one business day before items or services are expected to be furnished, the “replacement” provider or facility must accept the expected charges reflected on the original provider's or facility's estimate.

The estimate will show the expected charges for items or services that a provider or facility expects to charge the individual. This estimate is based on information known at the time the estimate is created and does not include any unknown or unexpected costs that may arise during the course of treatment. For example, an individual could be charged more if complications develop.

No Surprises Act

Overview of Key Consumer Protections

Required Timeframes for Providing Good Faith Estimates

Facilities and convening providers must provide good faith estimates within the following timeframes:

- The estimate must be provided no later than one business day after scheduling if the service is scheduled 3 to 9 business days in advance of the date the item or service is to be furnished.
- The estimate must be provided no later than three business days after scheduling if the service is scheduled at least 10 days in advance of the date the item or service is to be furnished.
- When an estimate is requested by an uninsured or self-pay individual, the estimate must be provided no later than three business days after the date of the request.

Good faith estimates are not required if the service is scheduled fewer than three business days in advance of the item or service to be furnished.

Example: How the Good Faith Estimate Works

Tonya is a 40-year-old with a long history of right knee pain. She does not have any form of health insurance. Tonya schedules an appointment with her orthopedist to receive a cortisone injection in her knee. Upon scheduling the appointment, her orthopedist sends her a good faith estimate totaling \$300. Tonya receives the injection and subsequently receives a bill from the orthopedist. The total billed charge is \$850.

Tonya would be able to challenge the bill using the Patient-Provider Dispute Resolution process because she is uninsured and the total billed charge from the orthopedist is at least \$400 above the good faith estimate.



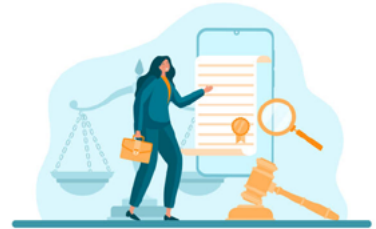
For additional information, please see the [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#); [Sample Good Faith Estimate for Uninsured or \(Self-Pay\) Individuals](#); and [Sample Good Faith Estimate Abbreviated Version](#).

No Surprises Act

Overview of Key Consumer Protections

No Surprises Act Expansion of External Review Rights

External review is a process where consumers can challenge a health plan's or health insurance issuer's denial of payment for a submitted claim for care. Internal appeals and external review laws require health plans and health insurance companies to provide a clear basis for claims denials and also require that consumers have the right for certain decisions by health plans or health insurance companies denying payment for care to be reviewed by an independent third party (sometimes referred to as an Independent Review Organization).



The No Surprises Act expands the right for consumers to seek an external review of health claim payment denials. The law extends external review to include consideration of whether a plan or issuer is in compliance with the No Surprises Act.¹²

How to Request an External Review

- **State External Review Processes:** Some states have their own external review processes. If there is a state external review process, the consumer should follow the instructions provided by their health plan or issuer or contact their state's Department of Insurance for more information. [See if your state has its own process here.](#)
- **Federal External Review Process:** If a consumer's state does not have its own external review process or if the state's external review process does not apply (for example, the consumer has a self-insured employer plan that is not subject to a state external review process), the consumer will need to use the federal external review process.¹³ Please see externalappeal.cms.gov for more information and to file a request for external review, or call 888-866-6205.
- Consumer advocates should determine if a consumer lives in a state with a [Consumer Assistance Program](#) and request assistance with insurance appeals and external review where appropriate. The steps to follow for filing an external review may differ based on the type of health coverage and where the consumer lives.

Note: In lieu of the external review process, individuals who are covered through an FEHB plan must use the Office of Personnel Management's disputed claims process to challenge an FEHB plan's coverage decisions regarding its compliance with surprise billing and cost-sharing protections under the No Surprises Act. The FEHB disputed claims process is explained in section 8 of FEHB plan brochures, which may be found at <https://www.opm.gov/healthcare-insurance/healthcare-plan-information/plans>.

Please see the following additional resources related to the external review process:

- [Healthcare.gov Appealing a Health Plan Decision: External Review](#)
- [Affordable Care Act: Working with States to Protect Consumers](#)
- [Department of Labor: Internal Claims and Appeals and External Review](#)

¹² Additionally, for plan years beginning on or after January 1, 2022, grandfathered plans are subject to external review processes for any adverse benefit determination involving the protections of the No Surprises Act.

¹³ If the consumer is covered by a self-funded health plan sponsored by a private-sector employer, they should check their Summary Plan Description for information about the plan's external review process.

No Surprises Act Overview of Key Consumer Protections

Examples: Denials Eligible for External Review

Example: Maria has health insurance through her employer. One day, she wakes up with severe pain in her abdomen. She is worried that it might be an appendicitis attack and goes to her local emergency room. Fortunately, it was not appendicitis, but the pain required immediate attention. Maria was treated for a stomach bug and discharged later that day. The plan denies payment because it doesn't believe the items and services received were emergency services. Because the denial of payment involves consideration of whether the issuer used the layperson's definition of an emergency medical condition required under the No Surprises Act, Maria can appeal the denial under the plan and, if the plan denies the appeal, Maria can use the external review process.

Example: A group health plan provides benefits for anesthesiology services. Duane has knee replacement surgery at a participating health care facility, and during the course of the surgery, receives anesthesiology services from an out-of-network provider. Because the provider was out-of-network, the health plan denies the claim. As a result, Duane is asked to pay out-of-network cost sharing. Because the No Surprises Act prohibits cost-sharing requirements in excess of in-network cost-sharing requirements for services from an out-of-network provider (including ancillary services) delivered at a participating health care facility, Duane can appeal this decision under the plan and, if the plan denies the appeal, Duane can use the external review process.

Transparency on Health Insurance Identification (ID) Cards

Note: In the future, regulations will be issued to implement this provision. In the meantime, health plans are expected to comply with ID card requirements using a good faith, reasonable interpretation of the No Surprises Act.

The No Surprises Act requires that health plans and issuers include information in clear writing on any ID cards (physical or electronic) issued to consumers. This information must explain:

- Any deductibles that may apply.
- Any out-of-pocket maximum limitations that may apply.
- A telephone number and website address to contact for more information.

See [FAQ Part 49 Question 4](#) for more information.



Improving the Accuracy of Provider Directory Information

Note: In the future, regulations will be issued to implement this provision. In the meantime, plans and issuers are expected to implement these provisions using a good faith, reasonable interpretation of the statute.

The No Surprises Act established processes and standards to improve the accuracy of health plan and issuer provider directories. Provider directories tell consumers whether their doctor or hospital is in-network with the plan. The directories can be found on the plan's public website.



Under the No Surprises Act, health plans and issuers must take steps to update and verify the accuracy of their provider directory information at least once every 90 days.

Health plans and issuers must:

- Establish a process to remove providers they are unable to verify as in-network providers within a specified timeframe.
- Establish a process to update their database within two business days of receiving directory changes from a provider or facility.
- Put provider directories or databases on a public website and include the name, address, specialty, telephone number, and digital contact information of each in-network provider or facility.
- Develop a process for responding, within one business day, to questions about the network status of a provider or a facility.

Under the No Surprises Act, providers and health care facilities also must have certain business processes in place to submit information to help keep provider directories current.¹⁴

If the Provider Directory Is Not Correct

If a health plan or issuer provider directory has the wrong information and the consumer receives care from an out-of-network provider or facility as a result, the plan is limited in what cost sharing they can impose on the consumer. The consumer cannot be subject to cost sharing that is more than the cost-sharing amount that would be charged for in-network services. In addition, the health insurance plan must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum and include on each applicable explanation of benefits certain required disclosures regarding balance billing protections.

The consumer is entitled to a full refund from a provider of any money paid over the in-network cost-sharing amount, plus interest, if:

- The consumer received out-of-network care due to inaccurate provider information;
- The provider or facility billed the enrollee for an amount in excess of the in-network cost-sharing amounts; and
- The consumer paid the bill.

¹⁴ See slide 22 of: [The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements](#).

Continuity of Care Protections

Note: In the future, regulations will be issued to implement this provision. In the meantime, health plans, health insurance issuers, providers, and facilities are expected to provide continuity of care using a good faith, reasonable interpretation of the No Surprises Act.



If a provider or facility ceases to be an in-network provider of a plan or issuer because the provider experiences a change in network status, the No Surprises Act allows consumers to have up to 90 days of continued health care benefits with that provider or facility under the same health plan terms and conditions if the patient is:

- Undergoing treatment for a serious and complex condition.
 - In the case of an acute illness, this is defined as a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
 - In the case of a chronic illness or condition, this is defined as a condition that is life-threatening, degenerative, potentially disabling, or congenital, and which requires specialized medical care over a prolonged period of time.
- Undergoing a course of institutional or inpatient care.
- Scheduled for non-elective surgery (including receipt of postoperative care from a surgery).
- Pregnant and receiving treatment for pregnancy.
- Receiving treatment for a terminal illness.

What Plans and Issuers Must Do

If a patient meets one of the above five criteria, the plan or issuer must:

- Notify the patient of the termination of their provider's in-network status and the patient's right to elect up to 90 days of continued transitional care from the provider or facility in a timely manner;
- Provide the patient an opportunity to notify the plan or issuer of the need for transitional care; and
- Permit the patient to elect to continue to have the same benefits provided, with respect to the course of treatment furnished by the provider or facility. Care must be provided under the same terms and conditions as would have applied under the plan or coverage had the termination not occurred.

What Providers and Facilities Must Do

For 90 days (starting on the date their plan or issuer notifies them of the change in network status), or until care is completed, whichever comes sooner, the treating provider or health care facility must:

- Accept payment from the health plan (and cost sharing from the individual) for items and services as payment in full; and
- Continue to adhere to the same policies, procedures, and quality standards.

No Surprises Act

Overview of Key Consumer Protections

Changes in Network Status

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

- The provider or health care facility's contractual relationship with the individual's plan or issuer is terminated for reasons other than failure to meet applicable quality standards or for fraud;
- The provider or health care facility's terms of participation in the plan or coverage change, resulting in a termination of benefits with respect to the provider or health care facility; or
- A group health plan's contract with a health insurance issuer offering health insurance coverage in connection with the plan is terminated, resulting in a loss of benefits provided under such plan with respect to the provider or health care facility.

If an individual is enrolled in a health benefits plan offered through the FEHB program, they have "transitional care" protections that are comparable to the No Surprises Act's "continuity of care" protections. They should refer to section 3 of their FEHB plan brochures which are available at <https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans>. To align with the No Surprises Act, FEHB plans must provide the current transitional care protections to persons in any trimester of pregnancy instead of just those in the second or third trimester.

Example: When Continuity of Care Provisions Apply

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

Per the No Surprises Act, continuity of care protections would apply to Joan with respect to the obstetrician, as the contract between the obstetrician and the plan was terminated for reasons other than failure to meet applicable quality standards or for fraud. In scenarios where a contract is terminated due to failure to meet quality standards or fraud, continuity of care protections wouldn't apply.

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





Who Has Protections Under the No Surprises Act

Types of Consumer Protections								
These protections apply to:	Surprise Billing Protections	Expanded External Review Process	Improved Accuracy of Provider Directories	Transparency on Health Insurance ID Cards	Continuity of Care Protections	Advanced Explanation of Benefits ¹	Good Faith Estimate for Uninsured (or Self-Pay) Individuals ²	Patient-Provider Dispute Resolution (PPDR) ³
Consumers enrolled in employment-based group health plans	✓	✓	✓	✓	✓	*		
Consumers enrolled in individual or group health insurance coverage on or outside the federal or state-based Marketplaces	✓	✓	✓	✓	✓	*		
Consumers enrolled in health benefits plans offered through the Federal Employees Health Benefits program ⁴ (FEHB)	✓	✓	✓	✓	✓	*		
Consumers enrolled in non-federal governmental plans that are sponsored by state and local government employers	✓	✓	✓	✓	✓	*		
Consumers enrolled in church health plans ⁵	✓	✓	✓	✓	✓	*		

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

Who Has Protections Under the No Surprises Act

Types of Consumer Protections								
These protections apply to:	Surprise Billing Protections	Expanded External Review Process	Improved Accuracy of Provider Directories	Transparency on Health Insurance ID Cards	Continuity of Care Protections	Advanced Explanation of Benefits ¹	Good Faith Estimate for Uninsured (or Self-Pay) Individuals ²	Patient Provider Dispute Resolution (PPDR) ³
Students enrolled in health insurance plans offered by colleges or universities	✓	✓	✓	✓	✓	*		
Consumers who are uninsured							✓	✓
Consumers who have health coverage listed above but are not using their coverage for the item or service (self-pay individuals)							✓	✓
Consumers with short-term, limited duration plans ⁶							✓	✓

Most protections went into effect for any health insurance plan year starting January 1, 2022. Good Faith Estimates for uninsured (or self-pay) individuals and Patient-Provider Dispute Resolution (PPDR) protections generally apply starting January 1, 2022.

¹ The provision for advanced explanation of benefits has not been implemented yet and is not currently enforced.

² The good faith estimate referenced in this column is for the uninsured or self-pay individuals. It is not referencing the good faith estimate that is included in the notice and consent form that out-of-network providers can use to request an insured individual's consent to waive No Surprises Act surprise billing protections.

³ Insured individuals who request a good faith estimate and ultimately decide to use their insurance aren't eligible for the Patient-Provider Dispute Resolution process; however, they could use their individual insurance or group health plan's internal claims and appeals process and external review process to appeal health insurance payment denials, including denials related to certain No Surprises Act surprise billing protections.

⁴ FEHB plans offer what is known as the "disputed claims process." This process continues to apply, without any changes, with respect to NSA disputed claims.

⁵ Church plans do not include health care sharing ministries, which are generally not considered health insurance coverage.

⁶ Consumers with short-term, limited duration plans are considered uninsured for the purpose of the good faith estimate requirement and the ability to utilize the Patient-Provider Dispute Resolution process.

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No Surprises Act Protections: Status of Implementation

The No Surprises Act established several new consumer protections against surprise medical billing (when “balance billing” occurs in certain circumstances) and other unexpected medical costs. The No Surprises Act was enacted in December 2020 and generally went into effect January 1, 2022. Through regulations and guidance, the Department of the Treasury, Department of Labor, and Department of Health and Human Services (HHS) (collectively, “the Departments”), along with the Office of Personnel Management, have implemented many of the consumer protections included in the No Surprises Act and have begun enforcement activity. The Departments will continue their efforts to implement and enforce all of the No Surprises Act protections.

This resource explains the status of key No Surprises Act protections. For more detail on some of the protections, please refer to the [No Surprises Act: Overview of Key Consumer Protections](#) resource. To find the latest updates, visit the [CMS No Surprises Act website](#), and the [Department of Labor website](#).

Protection	Status	Notes and References
<p>Surprise Billing Protection:</p> <p>Prohibits out-of-network providers, facilities, and providers of air ambulance services from balance billing many insured consumers¹ for emergency services, certain non-emergency items and services, and air ambulance services.</p>	In effect	<p>The Departments issued interim final rules and final rules outlining the regulations that apply to coverage of emergency services, certain non-emergency services, and out-of-network air ambulance services. The rules are in effect and the Departments are enforcing them. You can find more information about these regulations below:</p> <p>Requirements Related to Surprise Billing; Part I</p> <p>Presentation: The No Surprises Act’s Prohibitions on Balancing Billing</p> <p>Requirements Related to Surprise Billing: Final Rules</p> <p>FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55</p>

¹ The No Surprises Act generally protects consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage through an employer, the Federal Employees Health Benefits Program, the Health Insurance Marketplace®, or an individual plan purchased directly from an insurance company. For a more complete list of the types of health coverage subject to the No Surprises Act, see [No Surprises Act: Overview of Key Consumer Protections](#). The reference to insured consumers here does not include Medicare and Medicaid. (Note: Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.)

No Surprises Act Protections: Status of Implementation

Protection	Status	Notes and References
<p>Surprise Billing Notice:</p> <p>Certain health care providers and facilities must make publicly available, post on a public website, and give to individuals a one-page notice about the No Surprises Act surprise billing protections.</p>	In effect	<p>Model disclosure notice and instructions</p>
<p>Cost-Sharing Protection:</p> <p>Limits cost sharing for out-of-network services, so the requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items and services were provided in-network when the No Surprises Act applies.</p> <p>Requires cost sharing for out-of-network services to count toward any in-network deductibles and out-of-pocket maximums when the No Surprises Act applies.</p>	In effect	<p>Requirements Related to Surprise Billing; Part I</p> <p>Presentation: The No Surprises Act's Prohibitions on Balancing Billing</p> <p>Requirements Related to Surprise Billing: Final Rules</p> <p>FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 60 (page 2)</p>
<p>Establishment of a federal Independent Dispute Resolution (IDR) Process:</p> <p>Providers, air ambulance providers, facilities, health plans, and health insurance issuers can use the newly established federal independent dispute resolution process to resolve payment disputes for certain out-of-network charges.</p>	In effect	<p>The federal IDR process settles certain payment disputes between providers, facilities, providers of air ambulance services, group health plans, and health insurance issuers. Participants, beneficiaries, and enrollees aren't part of the IDR process and aren't affected by IDR determinations.</p> <p>Requirements Related to Surprise Billing; Part I</p> <p>Requirements Related to Surprise Billing; Part II</p> <p>Requirements Related to Surprise Billing: Final Rules</p>

No Surprises Act Protections: Status of Implementation

Protection	Status	Notes and References
<p>Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals:</p> <p>A provider or facility must provide uninsured (or self-pay) individuals a GFE of expected charges for items or services in certain circumstances.</p>	<p>In effect (except for the provision described below about including GFE information from co-providers and co-facilities).</p> <p>In the future, the Departments will enforce the requirement for good faith estimates for the uninsured (or self-pay) individuals to include information from co-providers and co-facilities.</p> <p>However, the enforcement of this protection has been delayed. HHS is not currently requiring GFEs to include cost estimates from co-providers and co-facilities. See the latest guidance for information regarding enforcement of this GFE requirement.</p>	<p>Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (PPDR) Process for Providers and Facilities as Established in Surprise Billing, Part II; Interim Final Rule with Comment Period (CMS 9908-IFC)</p> <p>Guidance on Good Faith Estimate and the Patient-Provider Dispute Resolution (PPDR) process for people without insurance or who plan to pay for the costs themselves</p> <p>FAQs About Consolidated Appropriations Act, 2021, Implementation – Good Faith Estimates (GFEs) for Uninsured (Or Self-Pay) Individuals – Part 1</p> <p>FAQs About Consolidated Appropriations Act, 2021, Implementation – Good Faith Estimates (GFEs) for Uninsured (Or Self-Pay) Individuals – Part 2</p> <p>FAQs About Consolidated Appropriations Act, 2021, Implementation – Good Faith Estimates (GFEs) for Uninsured (Or Self-Pay) Individuals – Part 3</p> <p>FAQs About Consolidated Appropriations Act, 2021, Implementation – Good Faith Estimates (GFEs) for Uninsured (Or Self-Pay) Individuals – Part 4</p> <p>Standard Notice: “Right to Receive a Good Faith Estimate of Expected Charges” Under the No Surprises Act (cms.gov)</p> <p>Examples of GFEs</p> <p>FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 60 (page 4)</p>

No Surprises Act Protections: Status of Implementation

Protection	Status	Notes and References
<p>Advanced Explanation of Benefits (AEOB):</p> <p>Requires health plans or health insurance issuers to send an AEOB to their insured patients that will explain the estimated cost of an item or service before a scheduled service.</p>	Delayed effective date	<p>Won't be enforced until the Departments complete the notice and comment rulemaking process to issue regulations to implement requirements for the AEOB provisions.</p> <p>See FAQ About Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49 for more information (page 6)</p> <p>Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals</p>
<p>Establishment of a Patient-Provider Dispute Resolution (PPDR) process for uninsured (or self-pay) individuals:</p> <p>Uninsured or self-pay patients who get a bill that is \$400 or more above the expected charges included on the Good Faith Estimate for a provider or facility may use the PPDR process to determine the payment amount.</p>	In effect	<p>PPDR Online Portal to start a dispute: https://nsa-idr.cms.gov/billdisputes/s/Requirements Related to Surprise Billing; Part II</p> <p>Guidance on Good Faith Estimate and the Patient-Provider Dispute Resolution (PPDR) process for people without insurance or who plan to pay for the costs themselves (page 6)</p> <p>Examples of good faith estimates and medical bills to help consumers know if they can dispute how much they must pay and if they are eligible to engage in the Patient-Provider Dispute Resolution (PPDR) process</p>
<p>Expanding the Scope of the External Review Process (appeal process for certain health plan decisions):</p> <p>Expands external review to include the ability to appeal a health plan's or issuer's coverage decisions about compliance with the surprise billing and cost-sharing protections.</p>	In effect	<p>Healthcare.gov – External Review Information</p> <p>CCIIO – HHS-Administered Federal External Review Process for Health Insurance Coverage</p> <p>What you need to know about the Biden-Harris Administration's Actions to Prevent Surprise Billing</p> <p>Guidance for States, Plans, and Issuers on State External Review Processes Regarding Requirements in the No Surprises Act</p> <p>Internal Claims and Appeals and the External Review Process Overview Technical Assistance Webinar</p>

No Surprises Act Protections: Status of Implementation

Protection	Status	Notes and References
<p>Transparency in Health Plan or Insurance Identification Cards:</p> <p>Requires health plans and issuers to include in clear writing, on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, or enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.</p>	<p>In effect</p> <p>Health plans may use any reasonable method to comply with ID requirements. The ID cards must give the required information to all participants, beneficiaries, and enrollees.</p>	<p>See FAQ About Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49 for more information (page 4)</p>
<p>Price Comparison Tool:</p> <p>Requires health plans and issuers to offer a price comparison tool and guidance that allow an enrolled individual to compare the amount of cost sharing across different providers.</p>	<p>Related requirements started taking effect January 1, 2023.</p>	<p>The Transparency in Coverage Final Rules contain requirements that overlap with the No Surprises Act's requirements for health plans to give cost-sharing estimates to consumers. See this FAQ on implementation (page 3).</p>



No Surprises Act Protections: Status of Implementation

Protection	Status	Notes and References
<p>Provider Directories:</p> <p>Requires health plans and issuers to maintain current network provider directories, verify and update the accuracy of provider directory information at least every 90 days, and protect enrollees from paying more than the in-network cost sharing amounts for services given by an out-of-network provider if the directory inaccurately showed the provider was in the network.</p>	<p>In effect</p> <p>The protection is in effect, but the regulations haven't been issued. Until that time, health plans and health insurance issuers won't be penalized as long as they have updated their directories using a good faith, reasonable interpretation of the No Surprises Act.</p> <p>Health plans may use any reasonable method to meet the provider directory requirements. Health plans may not impose higher cost-sharing amounts than those for in-network providers when a directory is inaccurate.</p>	<p>See FAQ About Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49 for more information (page 8)</p>

No Surprises Act Protections: Status of Implementation

Protection	Status	Notes and References
<p>Continuity of Care Protections:</p> <p>Ensures continuing coverage of certain medical services and items for eligible patients for up to 90 days at an in-network cost-sharing amount. The protections apply if the contract between their provider or facility and their health plan or issuer is ended or changes, and the provider or facility is no longer in-network for the patient.</p>	<p>In effect</p> <p>The protection is in effect, but the regulations haven't been issued. Until then, health plans and issuers must continue to provide benefits using a reasonable interpretation of the No Surprises Act.</p> <p>Once the regulation is published, Departments will give a reasonable amount of time for health plans and issuers to comply.</p>	<p>See FAQ About Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49 for more information (page 9)</p>





When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use

Under the No Surprises Act, a health care provider or facility can ask a consumer to waive their surprise billing and in-network cost-sharing protections in certain circumstances and if specific requirements are met by the provider or facility. This is called the “notice and consent exception.” For more information, see the [Decision Tree: Notice and Consent](#). For definitions of terms used in this document, refer to the [No Surprises Act Consumer Advocate Toolkit Glossary](#).

Notice and Consent Exception for Emergency Condition Post-Stabilization Services

When the Notice and Consent Exception Can Be Applied:

When a nonparticipating provider or nonparticipating emergency facility provides post-stabilization services and all the following requirements are met:

- The attending emergency physician or treating provider determines that a consumer is stable enough to travel using nonmedical or nonemergency medical transport to an available participating health care facility located within a reasonable travel distance given the consumer’s medical condition.
- The consumer or their authorized representative is in a condition (as determined by the attending emergency physician or treating provider using appropriate medical judgment) where they can receive information and provide informed consent.
- The provider/facility provides written notice and obtains written consent from the consumer to waive surprise billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.
- The provider/facility complies with applicable state laws.



When the Notice and Consent Exception Cannot Be Applied:

- When a nonparticipating provider or nonparticipating emergency facility provides emergency services prior to stabilization, including medical exams and treatment to stabilize a consumer, in connection with those services.
- The items or services are furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.
- If any one of the requirements listed in the box above are not met.
- Additional situations banned by state law.



When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use

Notice and Consent Exceptions for Non-Emergency Services

When the Notice and Consent Exception **Can Be Applied:**

When a nonparticipating provider provides non-emergency services that are for a patient visit to an in-network health care facility and all the following are true:

- The items or services do **not** meet the definition of ancillary services (see below); and
- The items or services were **not** furnished as a result of unforeseen, urgent medical needs that arose during the time the item or service was furnished; and
- The provider gives written notice and gets written consent from the consumer to waive the surprise billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.



When the Notice and Consent Exception **Cannot Be Applied:**

- The items and services are ancillary services, defined as:
 - Items and services related to emergency medicine, anesthesiology, pathology, radiology, neonatology, whether 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.
 - Items and services provided by an out-of-network provider if there is no in-network provider who can provide the item or service at the in-network health care facility.
- The items or services are provided as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.
- Additional situations banned by state law.





Health Insurance Basics



This document explains key health insurance concepts that may be helpful to consumers in understanding their health coverage as well as to consumer advocates who help individuals resolve medical billing problems. This resource is not intended to describe everything that is important to know about insurance. For more complete information, see the [Coverage to Care](#) resources developed by the Centers for Medicare & Medicaid Services.

What is Health Insurance and Why is it Important?

Health insurance is a legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company. Health insurance provides important financial protection in case you have an accident or sickness. For example, health insurance may help to pay for doctors' services, medications, hospital care, and special equipment when someone is sick or injured, often in exchange for a monthly premium. It may help cover a stay at a rehabilitation hospital or even a portion of home health care. Health insurance can also keep a consumer's costs down when they are not sick. For example, it can help pay for routine check-ups. Most health insurance also covers many preventive services at no cost, such as immunizations and cancer screening and counseling.

What is a Health Insurance Plan (also called a health plan or policy)?

A health insurance plan includes a package of covered health care items and services and sets how much it will pay for those items and services. In other words, a health plan will describe the types of health care items and services it will cover (help pay for), how much it will pay for those items and services (or groups of items and services), and for how long. Plans are often designed to last for a year at a time (known as a "plan year" or "policy year"). A health plan may be a benefit that an employer, union, or other group sponsor provides to employees or members to pay for their health care services.

What are Some Types of Health Care Coverage?

Health care coverage is often grouped into two general categories: private and public. The majority of people in the U.S. have private insurance, which they receive through their employer (which may include non-government employers or government employers at the federal, state or local level), buy directly from an insurance company, or buy through a Health Insurance Marketplace¹. Some people have public health care coverage through government programs such as Medicare, Medicaid, or the Veteran's Health Administration.

Health care coverage can also be categorized by the scope of benefits it offers or how long the coverage lasts. Health insurance often includes a wide range of covered services, including emergency and non-emergency services as well mental health benefits. Some people have very limited insurance plans, such as plans with benefits for only specific conditions or diseases (included in the list of "[excepted benefits](#)" under the Affordable Care Act, such as vision-only plans or cancer plans).

¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

As noted above, many health plans offer coverage for a year. However, some plans offer coverage for less than 12 months, including plans created to fill gaps in coverage. These plans are called short-term limited duration plans, and they often offer fewer benefits as compared to other health plans and lack some of the consumer protections available under other forms of coverage.

Self-Insured Employer Plans vs. Fully-Insured Plans

For consumers who receive health insurance through their employer, there are typically two different funding structures employers use to provide coverage:

- Some employers offer health care coverage to their employees through a self-insured plan. This is a type of health plan that is usually offered by larger companies where the employer collects contributions from employees via payroll deductions and takes on the responsibility of paying all related medical claims. These employers can contract with a third-party administrator (in some cases, a health insurance company acting as an administrator) for services such as enrollment, claims processing, and managing provider networks. Alternatively, these employers can self-administer the services. Self-insured plans are regulated by the federal government and are generally not subject to state insurance laws.
- A fully-insured employer plan is a health plan purchased by an employer from an insurance company. The insurance company, instead of the employer, takes on the responsibility of paying employees' and dependents' medical claims in exchange for a premium from the employer.



Does a Health Plan Typically Pay for Services from Any Doctor?

Not always. Some types of plans encourage or require consumers to get care from a specific set of doctors, hospitals, pharmacies, and other medical service providers who have entered into contracts with the plan to provide items and services at a negotiated rate. The providers in this designated set or network of providers are called “in-network” providers.

- **In-Network Provider:** A provider who has a contract with a plan to provide health care items and services at a negotiated (or discounted) rate to consumers enrolled in the plan. Consumers will generally pay less if they see a provider in the network. These providers may also be called “preferred providers” or “participating providers.”
- **Out-of-Network Provider:** A provider who doesn't have a contract with a plan to provide health care items and services. If a plan covers out-of-network services, *the consumer usually pays more to see an out-of-network provider than an in-network provider.* If a plan does not cover out-of-network services, then the consumer may, in most non-emergency instances, be responsible for paying the full amount charged by the out-of-network provider. Out-of-network providers may also be called “non-preferred” or “non-participating” providers.



Some examples of plan types that use provider networks include the following:

- **Health Maintenance Organization (HMO):** A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency, or when a prior authorization to obtain care outside the network has been approved, or as otherwise required by law. An HMO may require a consumer to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. An HMO may require enrollees to obtain a referral from a primary care doctor to access other specialists.
- **Exclusive Provider Organization (EPO):** A type of health plan where services are generally covered only if the consumer uses in-network doctors, specialists, or hospitals (except in an emergency). In general, EPOs do not require a referral from a primary care doctor to see other specialists, and in general there is very limited, if any, out-of-network coverage.
- **Point of Service (POS):** A type of plan where a consumer pays less if they use in-network doctors, hospitals, and other health care providers. POS plans may require consumers to get a referral from their primary care doctor in order to see a specialist.
- **Preferred Provider Organization (PPO):** A type of health plan where consumers pay less if they use in-network providers. They can use out-of-network doctors, hospitals, and providers without a referral for an additional cost.

Consumers can contact their insurance company or health plan to find out which providers are in-network. Health plans usually have online provider directories that tell patients whether their doctor, other provider, or hospital is in-network with the health plan. It is important to remember that networks can change. It's a good idea for consumers to check with their provider about whether they are in-network each time they make an appointment, so they know how much they will have to pay.



If a consumer has health coverage and receives care from an out-of-network provider or facility, their health plan might not cover the entire cost. Sometimes the out-of-network provider or facility could ask the consumer to pay the difference between the billed charge and the amount their health plan covers. This type of bill is called a "balance bill" or a "surprise bill." The No Surprises Act, a recent federal law, prohibits surprise billing in some circumstances. See the [No Surprises Act: Overview of Key Consumer Protections](#).

Insurance Costs

Consumers typically pay the following types of costs when they have insurance.

- **Premium:** The premium is an amount of money a consumer pays for a health insurance plan. The consumer and/or their employer usually make this payment bi-weekly, monthly, quarterly, or yearly. The premium must be paid regardless of how many services, if any, the consumer uses.
- **Cost Sharing:** Cost sharing is the share of costs for covered services that consumers must pay out of pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for out-of-network providers, or the cost of non-covered services. Cost sharing in Medicaid and Children's Health Insurance Program also includes premiums.
- **Deductible:** The amount a consumer must pay for covered health care services received before their plan begins to pay. For example, if a consumer's deductible is \$1,000, their plan won't pay anything until the consumer has paid \$1,000 for covered health care services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. For example, a plan may have separate in-network and out-of-network deductibles.
- **Copayment:** A fixed amount (\$20, for example) that a consumer pays for a covered health care service after they've paid their deductible.
- **Coinsurance:** The percentage of the costs of a covered health care service that a consumer pays (for example, 15% of the cost of a prescription) after paying a deductible.



See Appendix A for examples of how cost sharing works.

Tips to Know:

- Sometimes consumers with most types of health insurance don't have to pay any cost sharing for certain services. This is often true for preventive services like flu shots and some cancer screenings. The goal is to keep enrollees healthy and catch health problems early.
- Many health insurance plans have an out-of-pocket maximum. This is the most a consumer could pay during a coverage period (usually one year) for their share of the costs of covered services. After they meet this limit, the plan will usually pay 100% of the allowed amount. This limit never includes the premiums, balance-billed charges, or care that the consumer's plan doesn't cover. Some plans don't count all of a consumer's copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.
- In the majority of situations, the most important document for tracking health insurance costs is usually called an Explanation of Benefits (EOB). The EOB is a summary of health care charges that a health plan may send after a consumer receives medical care. It is not a bill. It shows the consumer how much their provider is charging the health plan for the care they received, and the amount the plan will cover. If the plan does not cover the entire cost, the provider may send the consumer a separate bill, unless prohibited by law.



Appendix A

Examples of Health Insurance Cost Sharing

This appendix provides some examples of how health insurance cost sharing works for consumers. These examples show different outcomes depending on whether a consumer has met their deductible and whether their health insurance includes out-of-network coverage. This information is intended to illustrate some of the basic steps that are typically used to calculate cost sharing in the absence of consumer surprise billing protections (or when such protections don't apply).

IN-NETWORK:

A consumer receives covered items or services from an in-network provider or facility.

If the services are covered by the consumer's health plan and furnished by an in-network provider or facility, the amount a consumer pays will vary based on whether the consumer has met their in-network deductible as well as the level of their coinsurance. Note the "allowed amount" is the maximum payment the plan will pay for a covered health care item or service and is generally the basis for cost-sharing calculations.

Based on their in-network status with the health plan, the provider may only charge the consumer up to the "allowed amount."

In the next two examples, assume the consumer's health plan specifies that coinsurance is 20 percent of the allowed amount after the consumer has met a \$2,000 deductible for in-network coverage.

1. The consumer has not paid anything toward the in-network deductible.	Example Amounts:
In-network provider bills health plan:	\$1,000
Health plan "allowed amount" for provider:	\$750
Health plan pays:	\$0 (since consumer has not met deductible)
Consumer owes:	\$750 (100 percent of allowed amount since consumer has not met deductible)
Provider bills consumer:	\$750
Total the consumer pays:	\$750



2. The consumer has fully met the in-network deductible.	Example Amounts:
In-network provider bills health plan:	\$1,000
Health plan "allowed amount" for provider:	\$750
Health plan pays:	\$600 (80 percent of allowed amount after deductible is met)
Consumer coinsurance owed:	\$150 (20 percent of allowed amount after deductible is met)
Provider bills consumer:	\$150
Total the consumer pays:	\$150

OUT-OF-NETWORK:

The consumer receives covered items or services from an out-of-network provider.

If the covered items or services are received out-of-network, a consumer's billed amounts will vary based on whether the consumer's health plan provides any out-of-network coverage and whether the consumer has met their out-of-network deductible.

In some circumstances, the No Surprises Act may limit what a consumer may be billed in each of the following examples. See the [No Surprises Act: Overview of Key Consumer Protections](#).



3. The consumer has no out-of-network coverage for the services.	Example Amounts:
Out-of-network provider bills health plan:	\$1,000 (claim subsequently rejected for lack of out-of-network coverage)
Health plan "allowed amount" for provider:	Not applicable – no out-of-network coverage
Health plan pays:	\$0 (since no out-of-network coverage)
Consumer coinsurance owed:	Not applicable – no out-of-network coverage
Provider bills consumer:	\$1,000 (provider bills full amount since consumer has no out-of-network coverage)
Total the consumer pays:	\$1,000

Health Insurance Basics

In the next two examples, the plan covers out-of-network services with consumer coinsurance of 40 percent after the consumer has met a \$4,000 deductible for out-of-network services. If the consumer has not paid anything toward the out-of-network deductible, the provider would bill the consumer for the full amount of the charges if the charges are less than \$4,000 (example 4). If the consumer has already paid their full deductible, a provider might balance bill a consumer for the difference between what the provider receives from the health plan and the provider's initial billed amount (example 5).

4. The consumer has not paid anything toward the out-of-network deductible.	Example Amounts:
Provider bills health plan:	\$1,000
Health plan "allowed amount" for provider:	\$550
Health plan pays:	\$0 (deductible not met)
Consumer owes:	\$550 (100 percent of allowed amount since consumer has not met deductible)
Provider bills consumer:	\$550 + possible \$450 balance billed
Total the consumer pays:	\$1,000 (\$550 + \$450)

5. The consumer has fully met the out-of-network deductible.	Example Amounts:
Provider bills health plan:	\$1,000
Health plan "allowed amount" for provider:	\$550
Health plan pays:	\$330 (60 percent of allowed amount after deductible is met)
Consumer coinsurance owed:	\$220 (40 percent of allowed amount after deductible is met)
Provider bills consumer:	\$220 + possibly \$450 balance billed
Total the consumer pays:	\$670 (\$220 + \$450)



2. Helping Consumers Who Receive Surprise Bills

[GO BACK TO TOC](#)



Key Words Related to Surprise Billing Protections



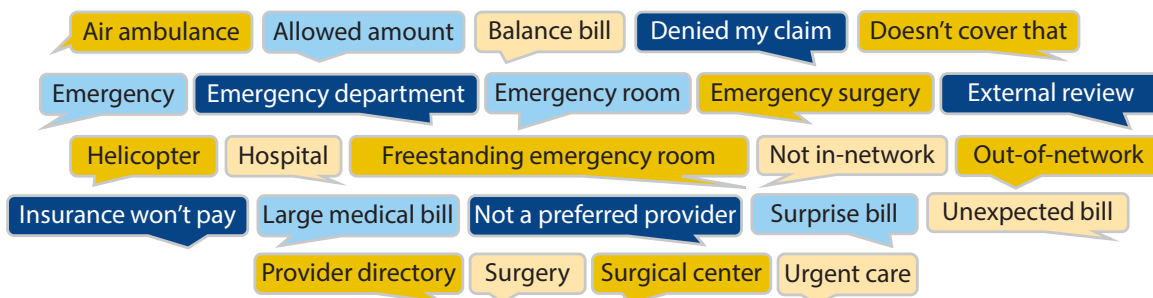
These are key words and phrases that consumer advocates (and others who assist individuals with medical bills) may hear when talking to consumers about unexpected or large medical bills. Listen or watch for these words when speaking with a consumer or reading an email. These words and phrases could signal that surprise billing protections apply or may have been violated under the No Surprises Act.

You can use this list as a standalone reference or together with the [No Surprises Act: Overview of Key Consumer Protections](#) fact sheet. For definitions of key terms related to the No Surprises Act, please refer to the [No Surprises Act Consumer Advocate Toolkit: Glossary](#).

Surprise Billing and External Review Protections

If these words or phrases are used, please consult the [Decision Tree: No Surprises Act Federal Surprise Billing Protections](#) to determine whether surprise billing protections apply in the consumer's situation.

Key Words



Key Phrases

- Had an emergency.
- Went to the emergency room.
- Went to the hospital.
- Went to urgent care for an emergency.
- Went to a surgical center.
- Had surgery.
- Rode in a helicopter or air ambulance.
- Got a large medical bill.
- Got an unexpected medical bill.
- Got a surprise bill.
- Got an Explanation of Benefits that shows my insurance might not cover the hospital bill or an item or service I got at the hospital.
- Got an unexpected medical bill for
 - Anesthesiology (including during pregnancy, labor and delivery).
 - Radiology (x-rays, imaging).
 - Pathology (lab tests such as blood work, biopsy).
 - Neonatology (infant care).
 - Lab services.

Key Words Related to Surprise Billing Protections

Surprise Billing and External Review Protections (continued)

- My insurance denied my claim because it wasn't medically necessary.
- My insurance denied me coverage/won't cover me because they said it requires prior approval/authorization.
- My insurance says my doctor is out-of-network or not in-network, or is not a preferred provider.
- I thought the hospital/facility or provider was in-network because I was told they were in-network.
- I thought this doctor or facility/hospital was in-network because they were listed in the directory from my health plan.
- I got the same services before, and the cost was much less.
- My insurance says they don't cover the item or service.
- My insurance won't cover my air ambulance transportation.
- I am confused or think my insurance didn't charge me the right co-pay.
- The amount I am being charged by my insurance doesn't seem right.
- Should I appeal my bill?

Notice and Consent to Waive Balance Billing Protections

If these words or phrases are used, consult the [Decision Tree: Notice and Consent](#) to determine whether notice and consent was provided appropriately in the consumer's situation.

Key Words



Key Phrases

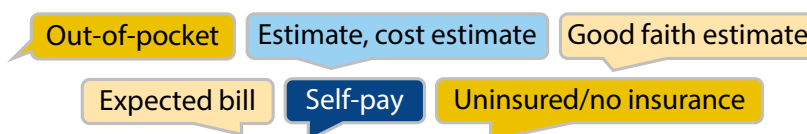
- My doctor or hospital (or my insurance) says I signed a consent form waiving my balance billing protections, but I don't remember signing that form or I did not sign.
- My doctor or hospital (or my insurance) says I signed a consent form waiving my balance billing protections, but I was given a bunch of paperwork to sign. I don't know what was in all the forms.
- I was given a consent form and told I had to sign.
- I wasn't given enough time/didn't have enough time to review a consent form before signing.
- I didn't have a choice whether to sign a consent form.
- I signed an electronic pad or tablet.
- No one asked me to sign anything.
- I revoked/took back my consent.
- My provider told me to sign a consent form before they treated me for my emergency.

Key Words Related to Surprise Billing Protections

Good Faith Estimates for Uninsured (or Self-Pay) Individuals and Patient-Provider Dispute Resolution

If these words or phrases are used, consult the [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#) and [Decision Tree: Patient-Provider Dispute Resolution Process](#) to navigate the good faith estimate and Patient-Provider Dispute Resolution protections.

Key Words



Key Phrases

For uninsured and self-pay consumers:

- The bill I got from the hospital or my doctor is really high.
- The bill I got from the hospital or my doctor is more than I expected.
- The bill I got from the hospital or my doctor is different from the cost estimate I received.
- The bill I got from the hospital or my doctor has charges from multiple doctors or facilities I didn't expect.
- I don't remember even seeing that person/ caregiver.
- Can I challenge a medical bill I got from my doctor or hospital?
- I was supposed to get a cost estimate, but never got it.
- I got the good faith estimate/cost estimate late or I didn't have enough time to review the estimate before my scheduled appointment.
- I got my cost estimate after I had the actual procedure.
- I used the government website to challenge the bill online but I don't agree with the decision. Can I appeal the decision? ("online" refers to the portal for the Patient-Provider Dispute Resolution process.)
- I filed a dispute online.

Other Protections: Consumer Financial Protection Board (CFPB) and Credit Reports

If these words or phrases are used, refer the consumer to the [Consumer Financial Protection Bureau](#) (see Next Steps).

- I don't think I should pay a medical bill, but my doctor sent the bill to collections.
- My medical debt is showing up on my credit report.
- I am disputing my medical bill (or I am using the dispute resolution process) and bill collectors are calling me.

Key Words Related to Surprise Billing Protections

Next Steps:

- For questions about the No Surprises Act or to report a possible violation of consumer protections, the consumer can contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint online at <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>.
- [Check for a consumer assistance program](#) (CAP) in your state¹.
- Consumers may also contact consumer help lines at the offices of either the Attorney General or Department of Insurance in their state.
- Consumers experiencing aggressive debt collection, coercive credit reporting, or other problems with a consumer financial product or service related to medical billing and collections can submit a complaint to the [Consumer Financial Protection Bureau](#) at consumerfinance.gov/complaint. For more information on Consumer Financial Protection Bureau protections, see this [bulletin](#).

¹ CAPs are not operating in every state. Please refer to the [CMS CAP page](#) to see if your state offers a CAP. If your state doesn't have a CAP, the map will direct you to other possible resources – such as the State Department of Insurance and the U.S. Department of Labor – including phone numbers, email addresses, direct mailing addresses, and websites.

Decision Tree: No Surprises Act Federal Surprise Billing Protections



This decision tree provides a series of questions to help consumer advocates assess whether the No Surprises Act surprise billing protections apply in a particular situation. It can be used during virtual or in-person consultations and is intended to be used with the [Decision Tree: Notice and Consent](#). For more information on these protections, see [No Surprises Act: Overview of Key Consumer Protections](#) and [The No Surprises Act's Prohibitions on Balancing Billing](#).

This decision tree begins with a set of general screening questions. Depending on the type of item or service that is involved, there are three separate decision tree sections:

1. Emergency services,
2. Non-emergency services provided by a non-participating provider at a participating facility, and
3. Air ambulance services provided by a non-participating provider of air ambulance services.

When using this decision tree, please note:

- For plan years or policy years beginning on or after January 1, 2022, the No Surprises Act provides new protections against surprise billing for people who have certain types of health coverage. The law provides different protections for uninsured and self-pay patients. Protections for uninsured or self-pay individuals are not addressed in this document.
- While the No Surprises Act provides new federal protections for consumers, state laws also may have similar provisions for either insured individuals, uninsured individuals, or both. The No Surprises Act supplements state surprise billing laws; it does not take the place of state law. For example, the No Surprises Act applies in instances where there is no applicable state law or a state law does not apply to a specific circumstance that is covered under federal law.
- Consumer advocates should research the existence of any state laws that may be relevant to a client's situation, as state laws may have additional or stronger protections than the No Surprises Act. See the [State Surprise Billing Laws and the No Surprises Act](#) and [Questions and Answers on the No Surprises Act and State Laws](#) for more information. This decision tree assumes that no state laws apply.

Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>. For more information on contacting the No Surprises Help Desk, see [No Surprises Act: How to Get Help and File a Complaint](#).

State Consumer Assistance Programs (CAPs) may also help with surprise billing questions. To see if your state has a CAP, please visit this [state listing](#).



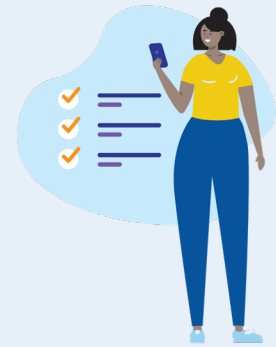
Decision Tree: No Surprises Act Federal Surprise Billing Protections

Documents Needed for a Consultation

When a consumer makes an appointment to discuss a surprise bill, ask them to bring the following documents if they have them available:

Key Documents

- Health insurance card(s) if the consumer is insured.
- Information on whether the consumer's plan is a self-insured plan (the consumer can call their employer's benefits office or the health insurance company to find out).
- Information about any gaps in health coverage, especially if they overlap with the date(s) of service in dispute.
- Medical bills.
- Explanation of Benefits statements.

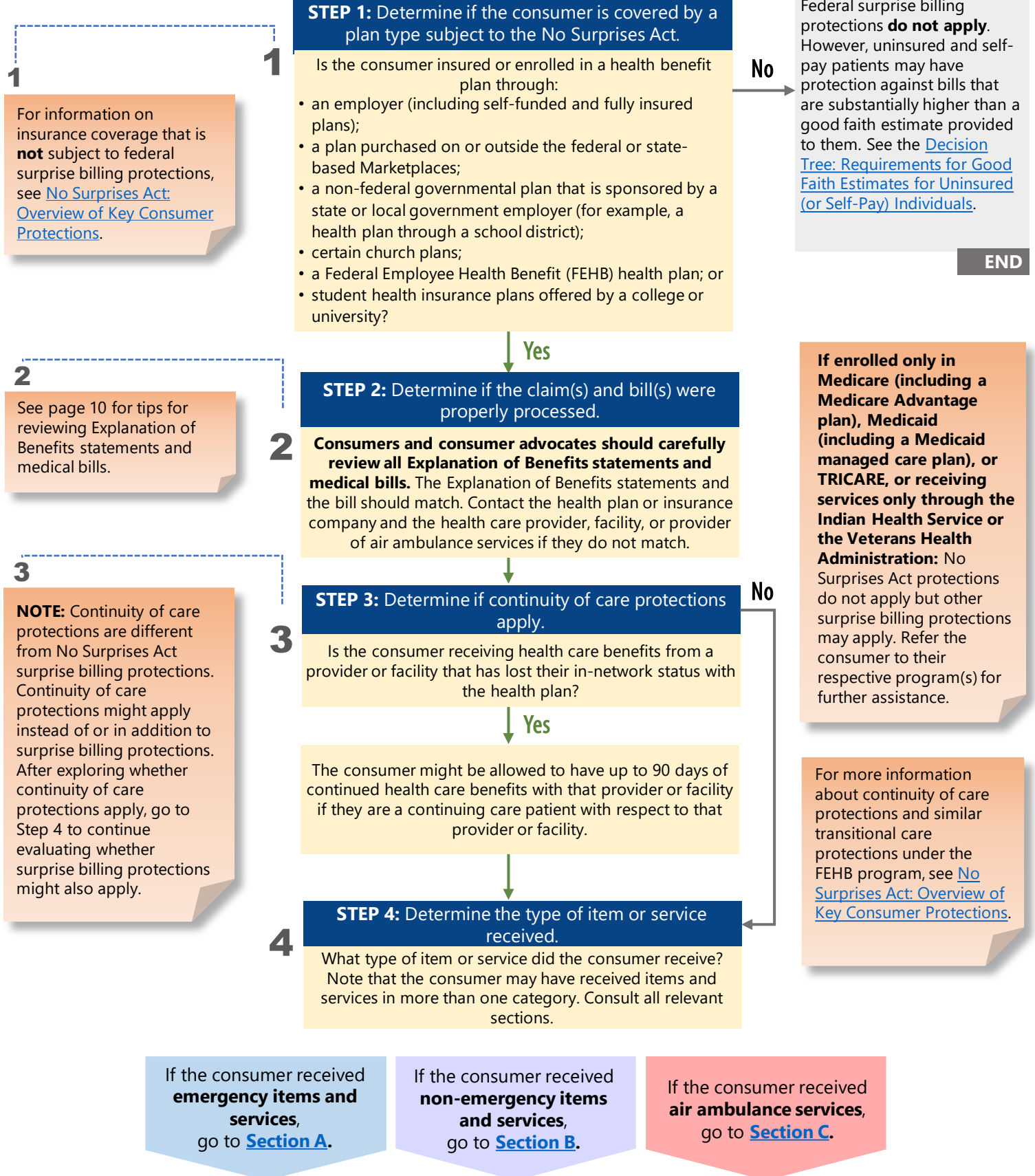


Other Helpful Information

- Consent forms the consumer or their representative may have signed waiving their balance billing protections.
- Good faith estimates received from health care providers, if any.
- Correspondence the consumer or their authorized representative has had with their health care provider, facility, air ambulance service provider, insurance company, health plan, or state or federal agency concerning billing disputes. All correspondence should include dates if possible.
- Notes from any phone calls with the health care provider, facility, air ambulance provider, insurance company, health plan, or state or federal agency.
- Records of any related medical bills the consumer has already paid, including co-pays, coinsurance, and deductibles.
- Communications concerning late fees or collection attempts for medical bills.
- Medical records related to the item(s) or service(s), such as discharge summaries.
- Documentation authorizing a representative to communicate on the consumer's behalf (if available, not required).
- Information posted on the provider or facility's website outlining surprise billing protections, including state and federal agency contact information.
- Summary plan description or certificate of coverage.

Decision Tree: No Surprises Act Federal Surprise Billing Protections

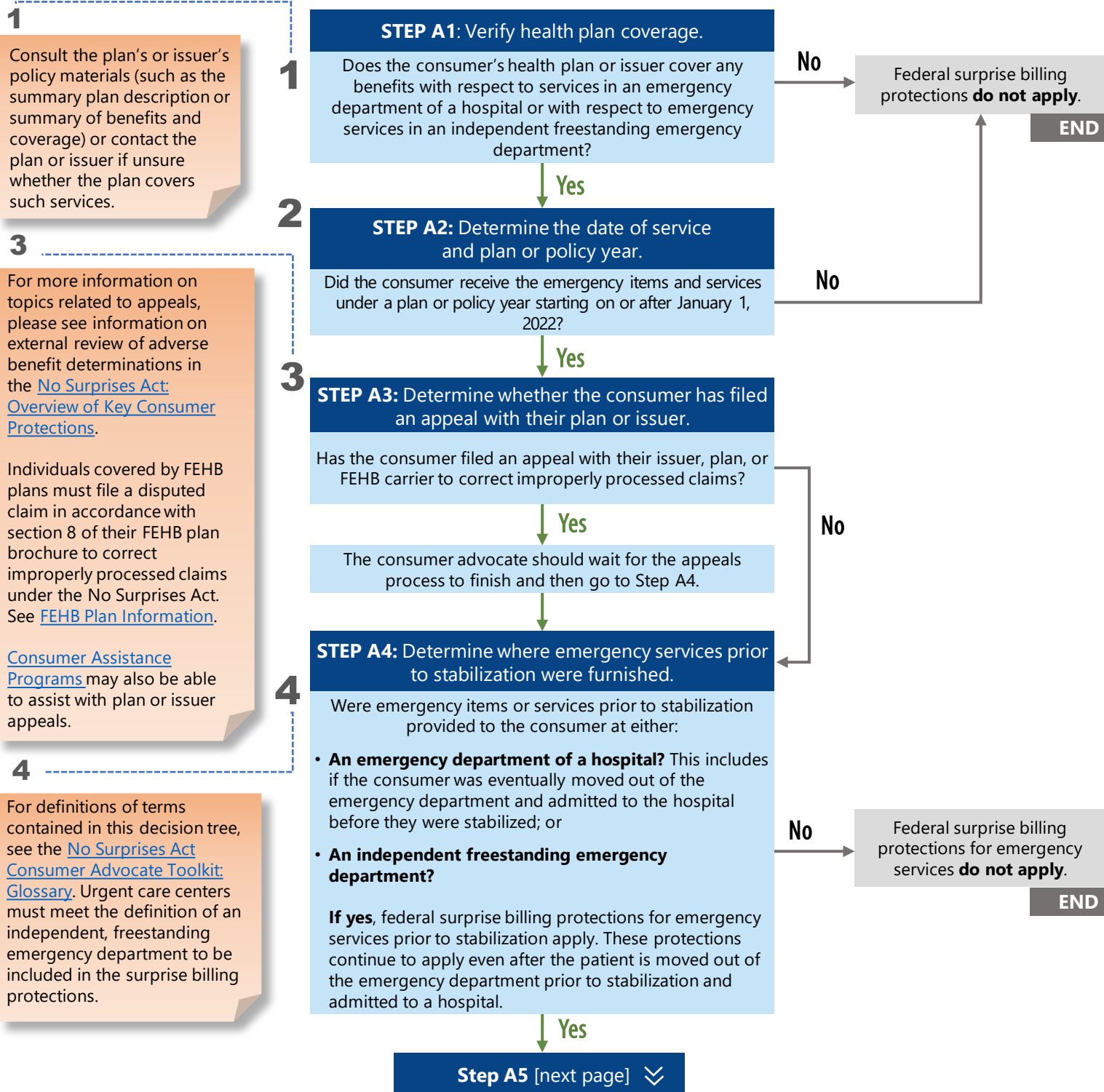
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Decision Tree: No Surprises Act Federal Surprise Billing Protections

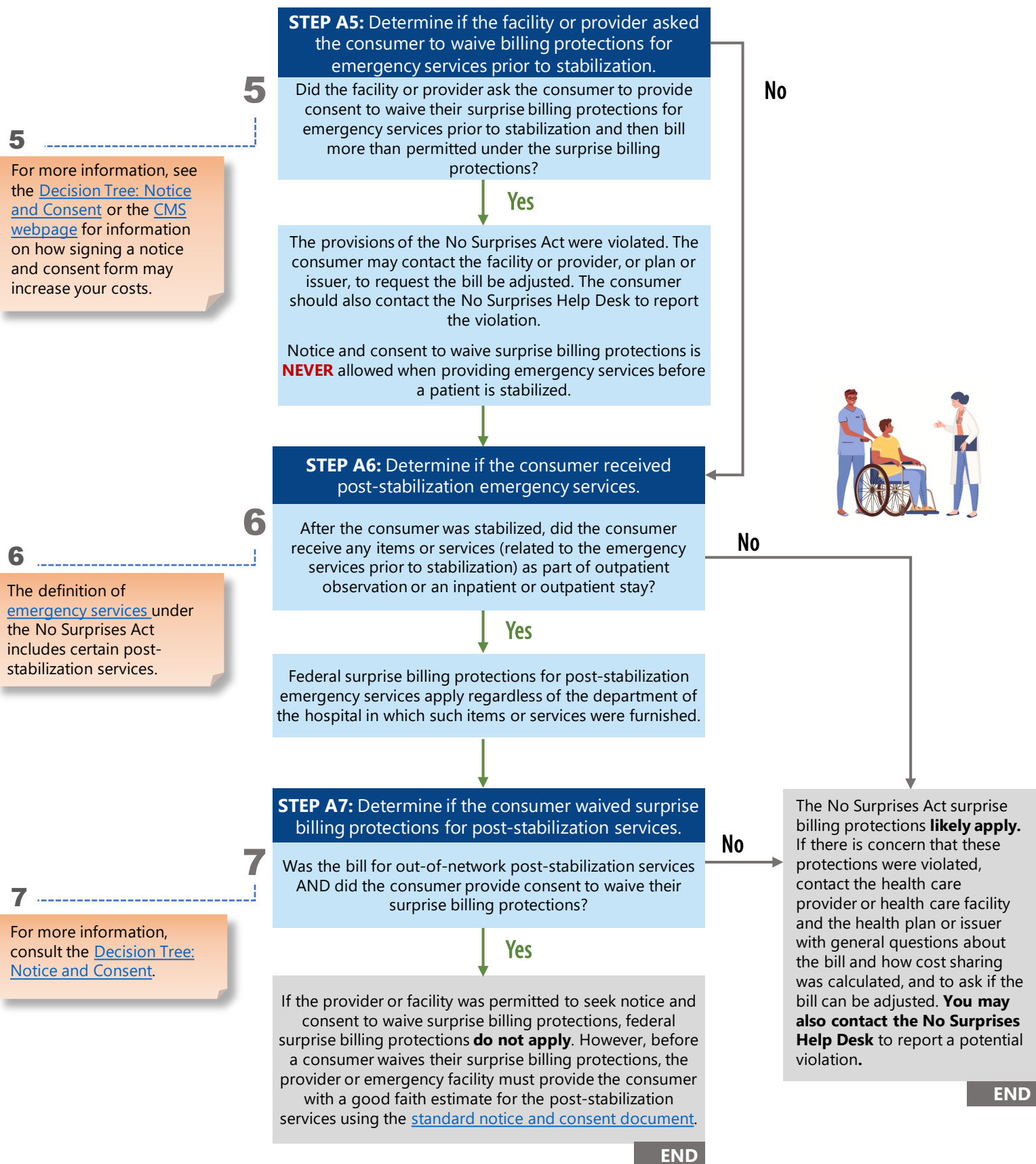
Section A: Emergency Items and Services

Under the No Surprises Act, **out-of-network providers** and **out-of-network emergency facilities** must not send surprise medical bills to consumers who receive an **emergency service** for an **emergency medical condition** at an **emergency facility**. In addition, when the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages. Out-of-network means that a provider or facility doesn't have a contractual relationship with an individual's health plan or issuer for the item or service provided.



Decision Tree: No Surprises Act Federal Surprise Billing Protections

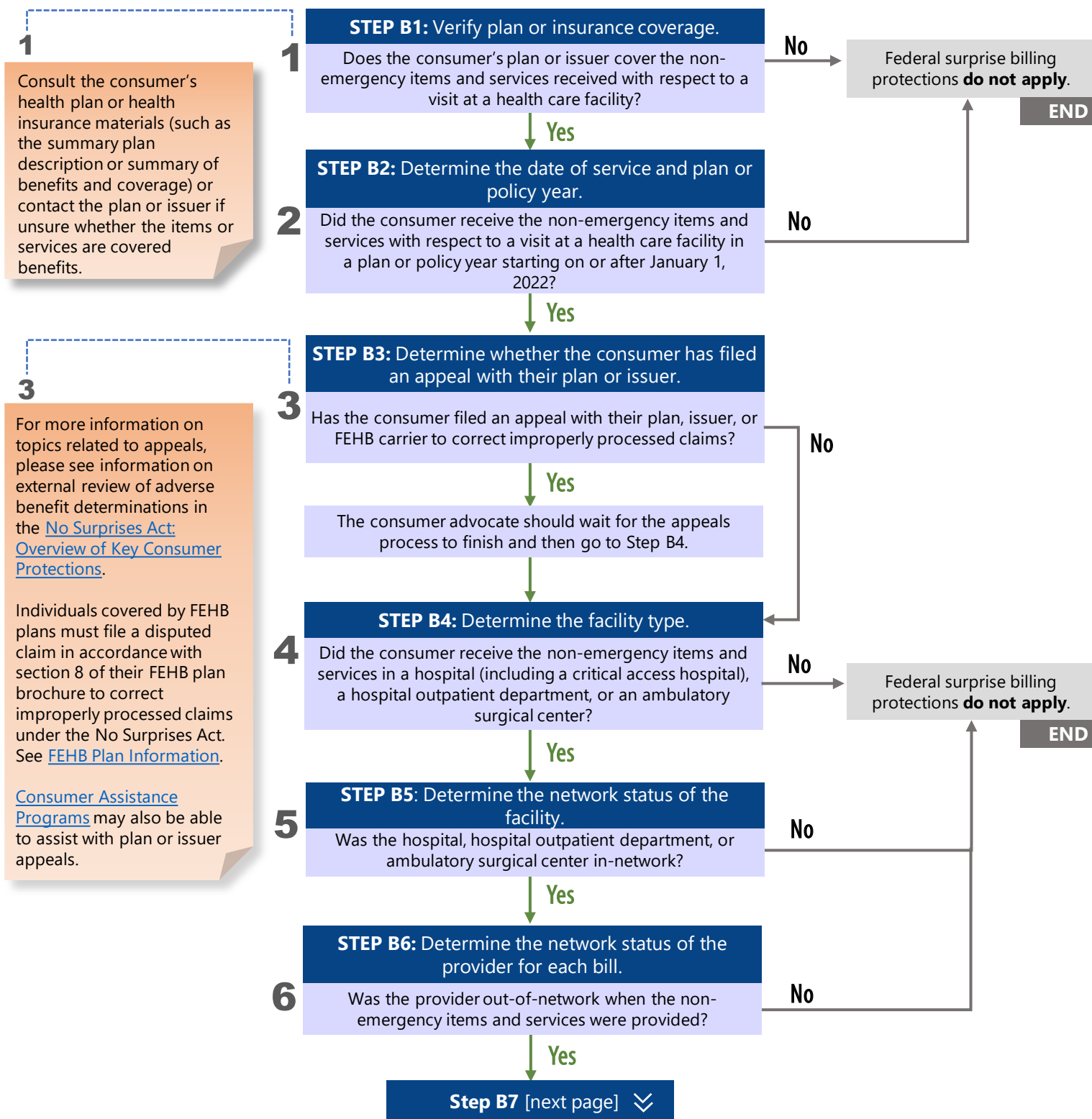
Section A: Emergency Items and Services



Decision Tree: No Surprises Act Federal Surprise Billing Protections

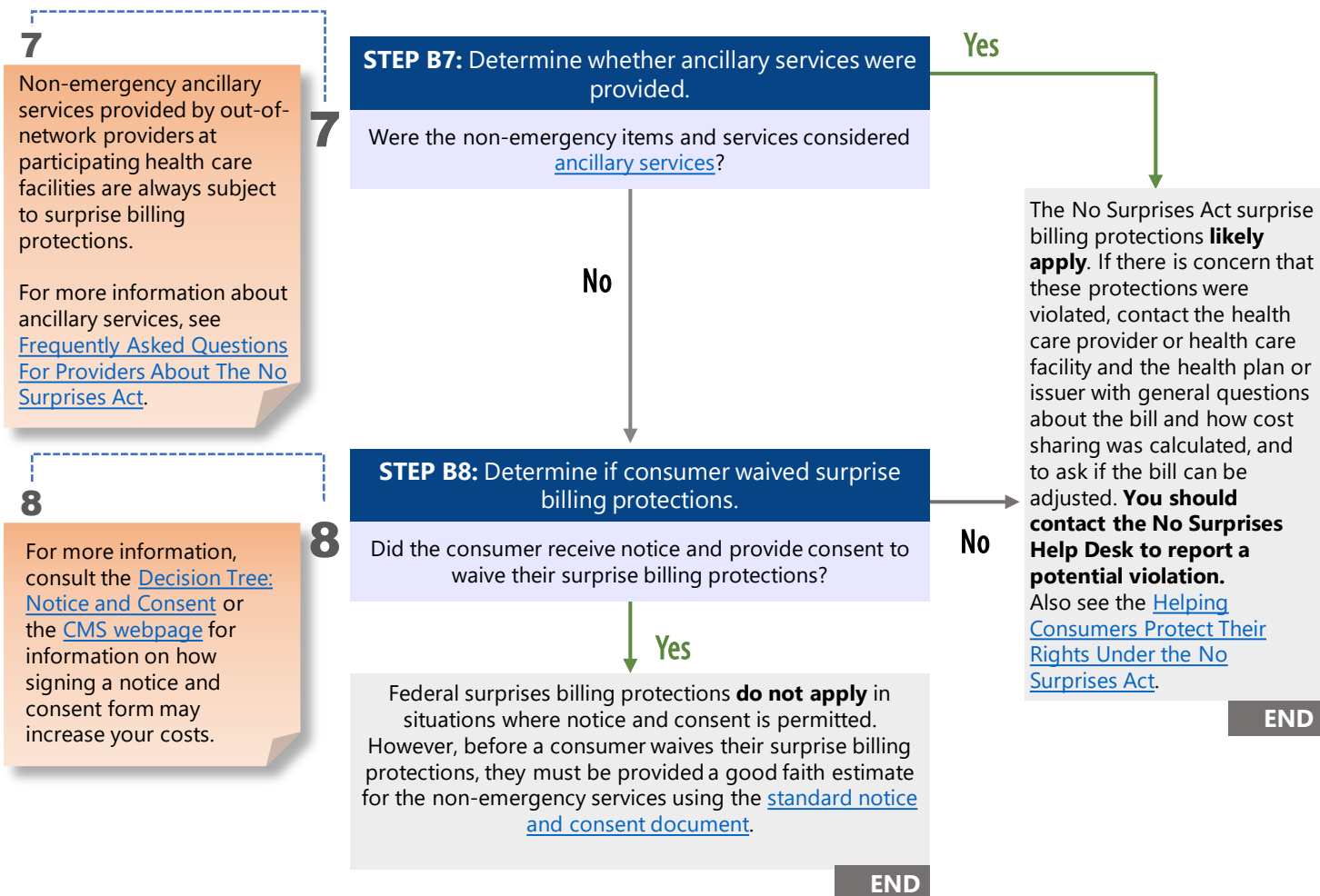
Section B: Non-Emergency Items and Services

Generally, under the No Surprises Act, **out-of-network providers** are prohibited from balance billing an individual who gets certain covered, non-emergency services that are **part of a visit to a participating health care facility**. When the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.



Decision Tree: No Surprises Act Federal Surprise Billing Protections

Section B: Non-Emergency Items and Services

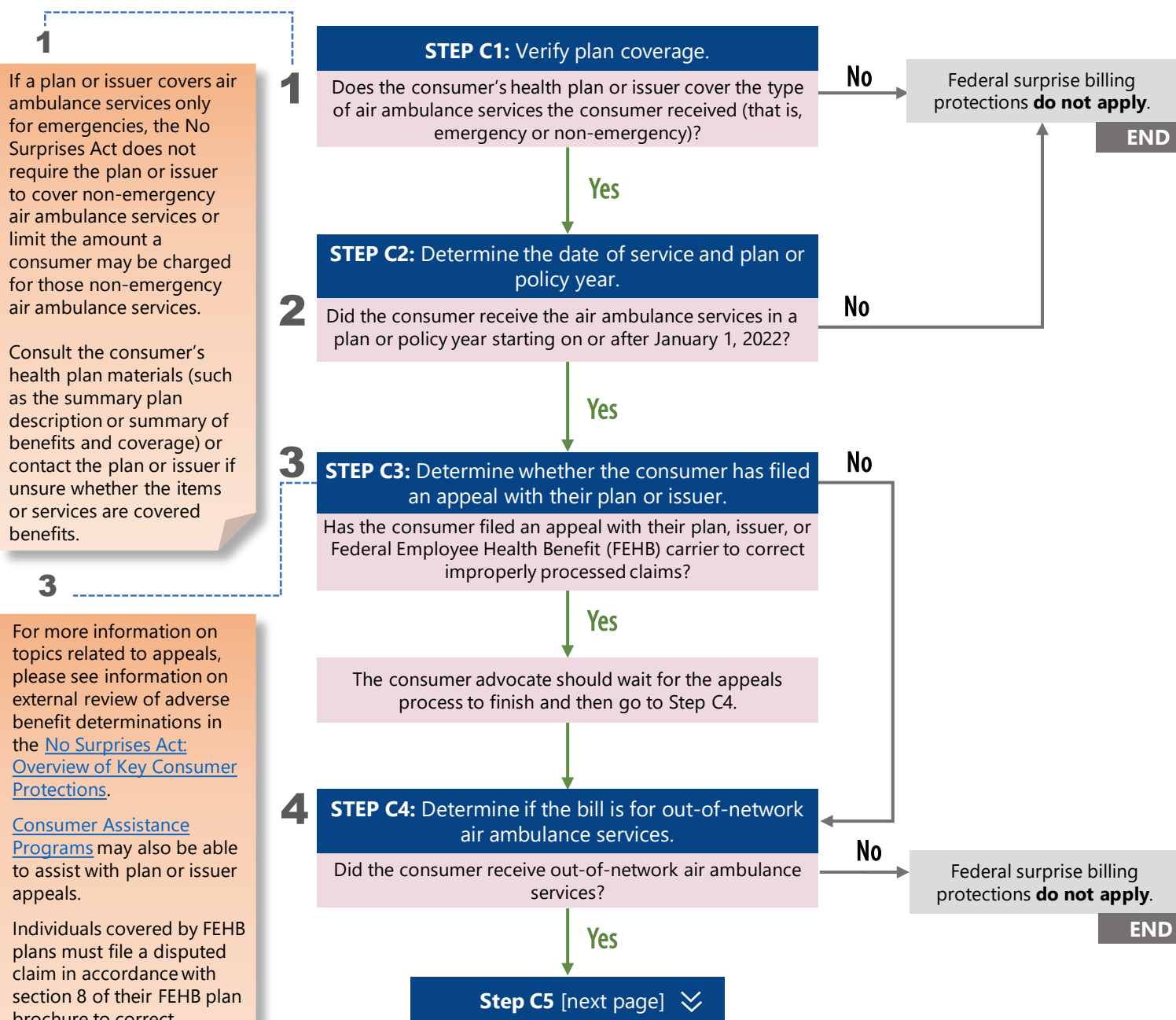


Decision Tree: No Surprises Act Federal Surprise Billing Protections

Section C: Air Ambulance Services

Under the No Surprises Act, **out-of-network air ambulance providers** are prohibited from balance billing an individual who receives covered air ambulance services. When the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

Note that ground ambulance services are not addressed under federal law. There may be other state or municipal laws limiting what emergency medical services providers can charge consumers. See if your state has a [Consumer Assistance Program](#) for more information on ground ambulance services.



Decision Tree: No Surprises Act Federal Surprise Billing Protections

Section C: Air Ambulance Services

For more information, consult the [Decision Tree: Notice and Consent](#) or the [CMS webpage](#) for information on how signing a notice and consent form may increase your costs.

5 STEP C5: Determine if the consumer waived surprise billing protections.

Did the consumer receive notice and provide consent to waive their surprise billing protections?

Yes

The provisions of the No Surprises Act were violated.
Air ambulance service providers may never seek an individual's consent to waive No Surprises Act protections for out-of-network air ambulance services.

The consumer may contact the air ambulance provider or plan or issuer to request the bill be adjusted. Contact the No Surprises Help Desk to report the violation.

END

No

The No Surprises Act surprise billing protections **likely apply**. If there is concern that these protections were violated, contact the air ambulance provider and the health plan or issuer with general questions about the bill and how cost sharing was calculated, and to ask if the bill can be adjusted. **You should also contact the No Surprises Help Desk to report a potential violation.**

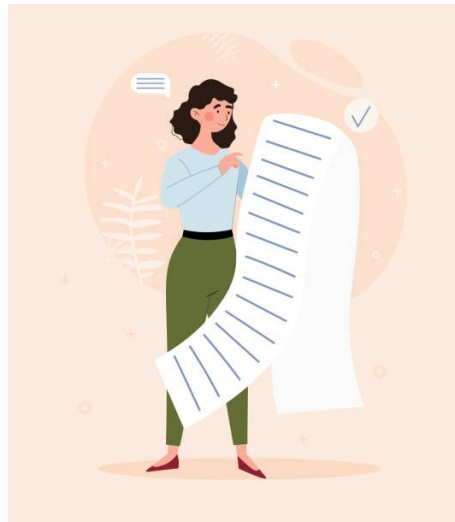
END



Decision Tree: No Surprises Act Federal Surprise Billing Protections

Tips for Reviewing Explanation of Benefits Statements and Medical Bills

- Providers, facilities, and providers of air ambulance services may submit a claim directly to the consumer's health plan or insurance, even if they are not an in-network provider.
- If a consumer has multiple sources of coverage, the providers, facilities, and providers of air ambulance services should submit claims to all of the sources.
- The health plan or insurance company must process claims promptly and alert the provider, facility, or provider of air ambulance services and consumer of the amount of cost sharing the consumer is liable to pay for the service.
- The cost-sharing amount should appear on the insurance statement, also called the Explanation of Benefits.
- The Explanation of Benefits must include a standard notice indicating that No Surprises Act protections apply for items and services subject to the No Surprises Act.
- Before paying any bills, the consumer should compare the bill to the Explanation of Benefits to make sure they match.
- If they do not match, call both the health plan or insurance company and the provider, facility, or provider of air ambulance services to find out why.



Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals



Introduction

Beginning January 1, 2022, the No Surprises Act requires **all** health care providers* and facilities to provide an estimate of expected charges within certain timeframes to:

- Consumers who do not have health coverage or those who lack coverage for a particular item or service; and
- Consumers who have certain types of health coverage but do not intend to use it (also known as “self-pay” individuals).

This estimate of charges is known as a “good faith estimate” and must be provided when such consumer schedules a service at least 3 days in advance or requests an estimate. Please note that this document **does not** address good faith estimates issued in connection with notice and consent to waive surprise billing protections. [Learn more about what a good faith estimate is](#), including how it is different from a bill for health care services.

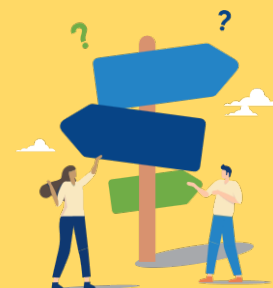
This decision tree lays out when a provider or facility must provide a good faith estimate to an uninsured (or self-pay) individual and what individuals should expect when receiving the good faith estimate. A separate [decision tree](#) details how to determine if the individual is eligible for the Patient-Provider Dispute Resolution process and what steps to take to initiate it.

*Throughout this document, the term “providers” also includes providers of air ambulance services.

Where can I go for help?

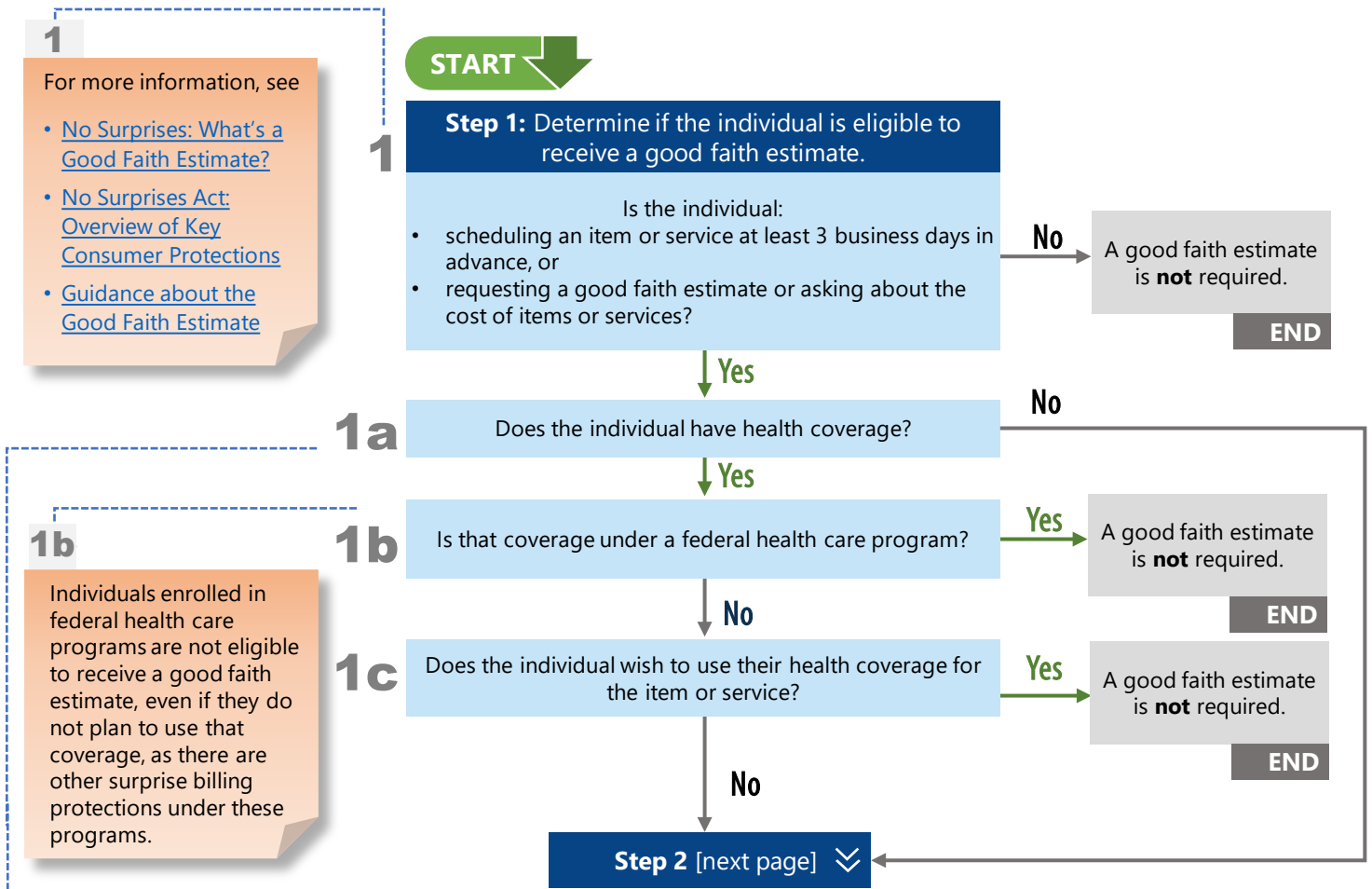
Contact the No Surprises Help Desk at 1-800-985-3059 or <https://www.cms.gov/medical-bill-rights>.

Also refer to the [No Surprises Act: How to Get Help and File a Complaint](#).



Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals

Before an individual receives health care: Follow the steps below to determine eligibility and rights to receive a good faith estimate.



1
For more information, see

- [No Surprises: What's a Good Faith Estimate?](#)
- [No Surprises Act: Overview of Key Consumer Protections](#)
- [Guidance about the Good Faith Estimate](#)

1b
Individuals enrolled in federal health care programs are not eligible to receive a good faith estimate, even if they do not plan to use that coverage, as there are other surprise billing protections under these programs.

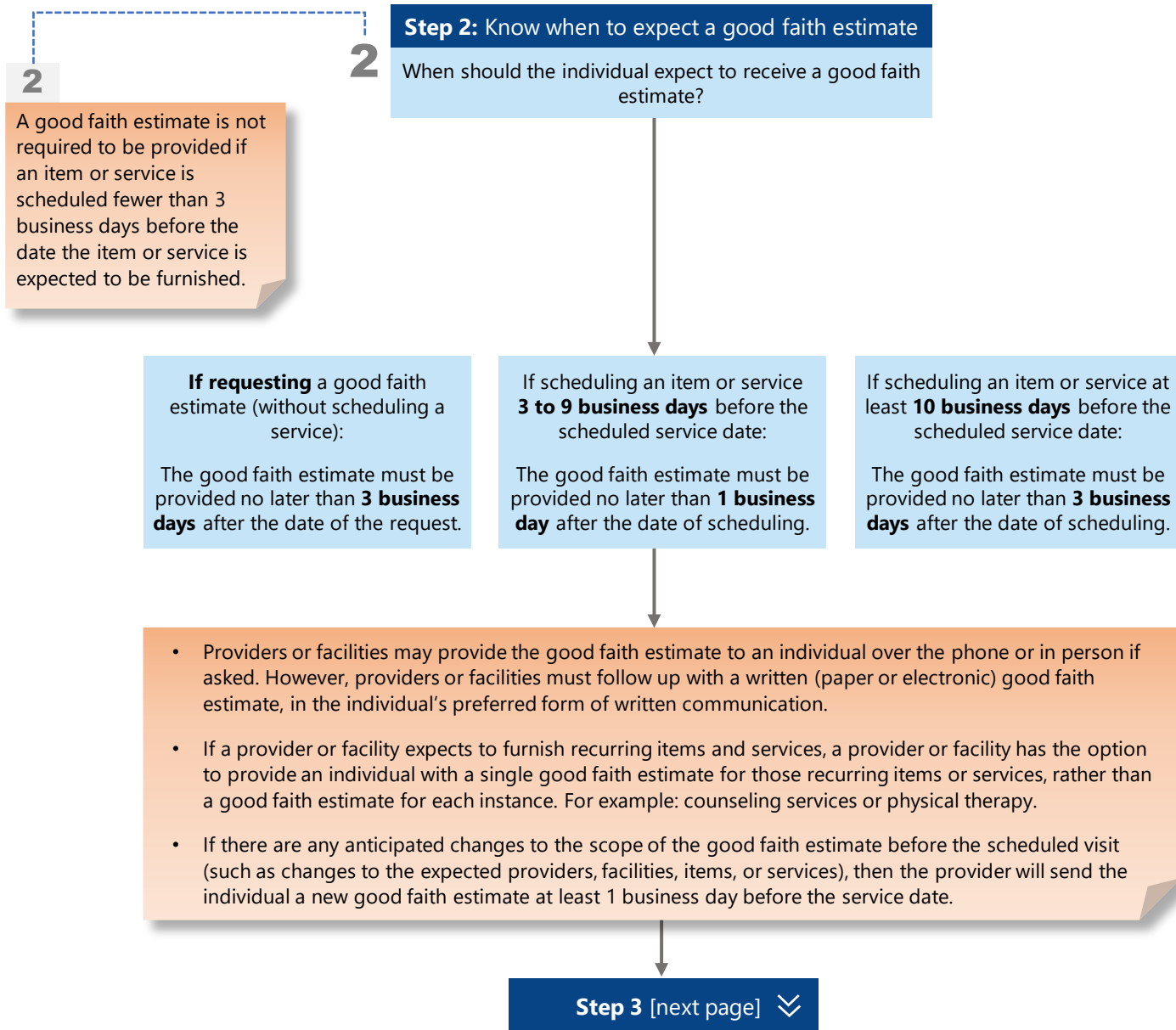
1a

Individuals with health coverage includes those with:

- A group health plan (a plan through their employer or union),
- Group or individual health insurance coverage offered by a health insurance issuer,
- A federal health care program (such as Medicaid (including Medicaid managed care plans), Medicare (including Medicare Advantage), or TRICARE), or
- A health benefits plan under the Federal Employees Health Benefits (FEHB) Program.

If an individual is **not** enrolled in any of the above (or is covered under a short-term limited duration plan), the individual is considered uninsured for the purposes of the good faith estimate requirements.

Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals



Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals

Step 3: Know what the good faith estimate contains

3

The good faith estimate must include (among other information):

- A list of items and services that the scheduling provider or facility reasonably expects to furnish for, and in conjunction with, the primary item or service, for that period of care.
- Applicable diagnosis codes and expected service codes.
- Expected charges or costs for each item or service.
- A list of items and services that will need to be scheduled with another provider or facility, either before or after the period of care for the primary item or service. Individuals will need to request separate good faith estimates from the providers they expect to see for these items and services.
- Information about the right to dispute a bill if the billed charges for any provider or facility is at least \$400 or more than the expected charges on the good faith estimate for that provider or facility.

See the [full list of required information](#) for a complete good faith estimate. See a [sample template](#) for a complete good faith estimate.

3

When consumers qualify for sliding fee discounts

Individuals may qualify for a provider's or facility's sliding fee discounted price. These individuals may receive a good faith estimate with the undiscounted price for items and services. This could happen if the provider or facility doesn't have the information they need to calculate the discounted prices. See [guidance](#) about good faith estimates when sliding scale discounts are offered.

3

When providers and facilities do not expect to bill a consumer

If a provider or facility does not expect to bill an individual for any items or services, the individual may receive an abbreviated good faith estimate, also called a Good Faith Estimate for No-Cost Health Care Items & Services. An abbreviated good faith estimate does not list any items or services and must state the provider's commitment not to bill the patient. See [guidance](#) about additional requirements for abbreviated good faith estimates.

Step 4 [next page]

The good faith estimate will:

- Include estimated costs of items and services reasonably expected to be provided based on information known at the time the estimate was created.
- Not include any unknown or unexpected costs that may arise during the course of treatment. For example, an individual could be charged more if complications or special circumstances occur.
- Not be required to include estimated costs for items and services expected to be provided by a co-provider or co-facility until a later time. The Department of Health and Human Services (HHS) will address the requirement for good faith estimates to include co-provider and co-facility information in future rulemaking.

Key Terms:

- A **convening provider** or convening facility is the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is (or in the case of a request, would be) responsible for scheduling the primary item or service.
- A **co-provider or co-facility** is a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.

Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals

4

Step 4: Compare the good faith estimate to the medical bill.

The individual should keep the good faith estimate in a safe place for purposes of comparing it to any bills received later. After an individual gets a bill for the items or services from a provider or facility, if the billed amount is \$400 or more above that provider's or facility's good faith estimate, the individual may be eligible to dispute the bill using the Patient-Provider Dispute Resolution Process.

For more information, review an [example of what a good faith estimate may include](#) and [examples of good faith estimates that do and don't qualify for the Patient-Provider Dispute Resolution process](#). See tips on [how to read a medical bill](#).

END

4

[Learn more about the dispute resolution process](#), including eligibility requirements and what information or documents are needed to start a dispute.

Refer to the [Decision Tree: Patient-Provider Dispute Resolution Process](#) for a step-by-step guide to that process.



Introduction

Beginning January 1, 2022, the No Surprises Act requires health care providers¹ and facilities to provide an estimate of expected charges to:

- Consumers who do not have health coverage or those who lack coverage for a particular item or service; and
- Consumers who have certain types of health coverage² but do not intend to use it (also known as “self-pay” individuals).

This estimate of charges is known as a “good faith estimate” and must be provided when such consumers schedule a service at least 3 business days in advance or request an estimate. If the actual billed charges from a provider or facility for a health care item or service are \$400 or more above the good faith estimate from that provider or facility, the consumer may challenge the bill using the patient-provider dispute resolution process. [Learn more about the dispute resolution process](#), including who may use it and what information or documents are needed to start a dispute. Consumers in any state can use the federal patient-provider dispute resolution process.

Once an individual without health insurance or a “self-pay” individual receives a good faith estimate, this decision tree lays out how to determine if the individual is eligible to use the patient-provider dispute resolution process and what steps to take in the process.

This decision tree is meant to be paired with the [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#).

Please refer to the [No Surprises Act Consumer Advocate Toolkit: Glossary](#) for definitions of terms.

Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or email FederalPPDRQuestions@cms.hhs.gov. For more information on contacting the No Surprises Help Desk, see [No Surprises Act: How to Get Help and File a Complaint](#).

State Consumer Assistance Programs (CAPs) may also help with questions on the patient-provider dispute resolution process. To see if your state has a CAP, please visit this [state listing](#).

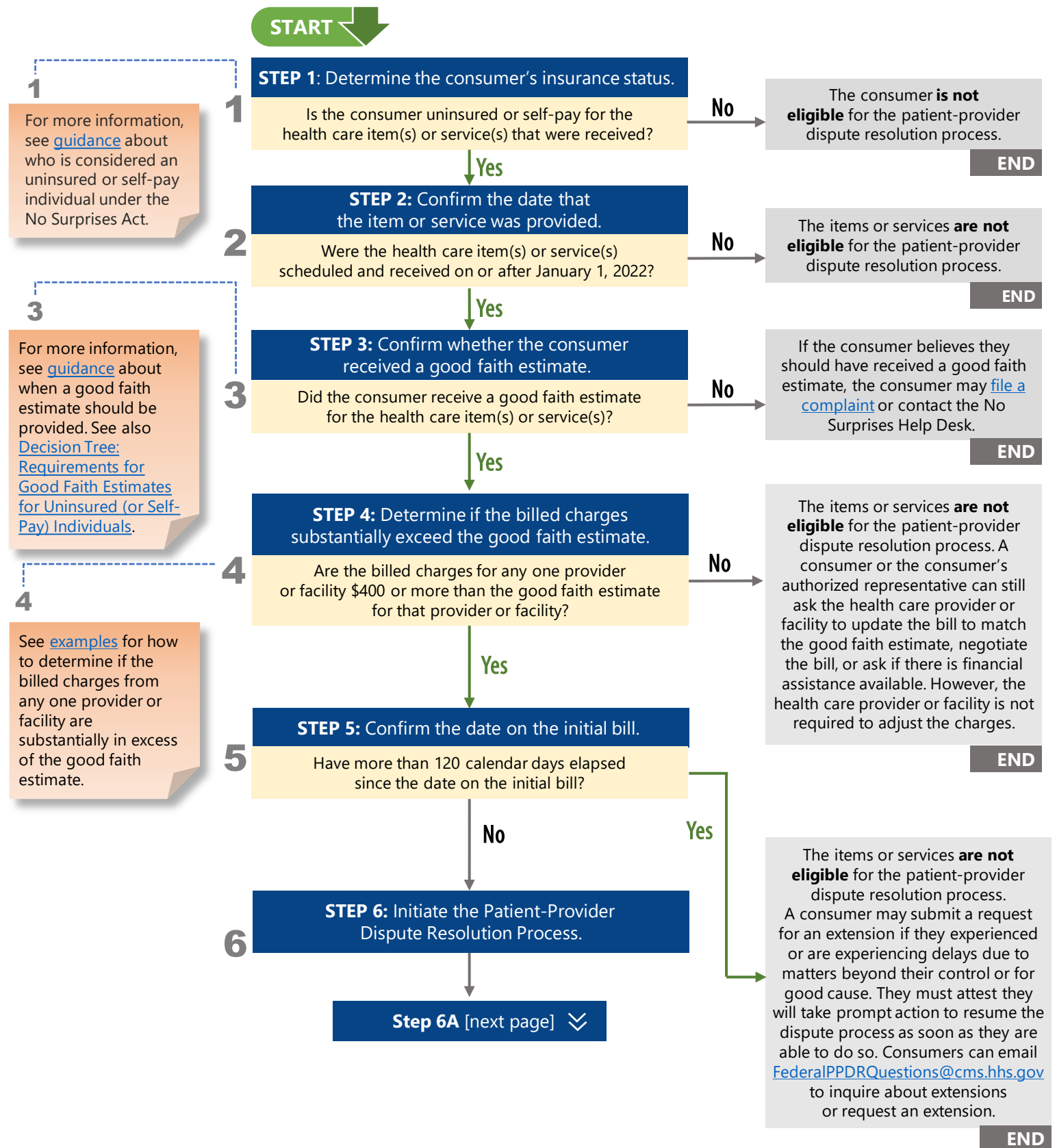


¹ Throughout this document, the term “providers” also includes providers of air ambulance services.

² Generally, this includes health coverage subject to the No Surprises Act protections.

Decision Tree: Patient-Provider Dispute Resolution Process

Determine if the Consumer is Eligible for the Patient-Provider Dispute Resolution Process



Decision Tree: Patient-Provider Dispute Resolution Process

The Steps of the Patient-Provider Dispute Resolution Process

STEP 6a: Initiate the patient-provider dispute resolution process.

6a

The consumer or their authorized representative can start the dispute resolution process by submitting a [Patient-Provider Dispute Resolution Initiation Form](#) and other relevant information to the Department of Health and Human Services (HHS). The notice can be submitted through the [online federal Independent Dispute Resolution portal](#) or by mail. **HHS strongly recommends that the initiation notice be submitted through the online portal to help ensure efficient processing.**

The Patient-Provider Dispute Resolution Initiation Form must be submitted electronically or postmarked within 120 calendar days of the date on the initial bill. If the form cannot be submitted via the online portal, download a copy of the [Patient-Provider Dispute Resolution Initiation Form](#) and mail it to:

C2C Innovative Solutions Inc., Patient-Provider Dispute Resolution
P.O. Box 45105 | Jacksonville, FL 32232-5105

6b

If the selected dispute resolution entity decides that the consumer should pay anything less than the billed charge, the \$25 administrative fee will be subtracted from the final amount the dispute resolution entity determines is due to the provider or facility.

STEP 6b: Pay the administrative fee to the selected dispute resolution entity.

6b

HHS will select a dispute resolution entity to handle the dispute. The consumer must pay a \$25 administrative fee to the selected dispute resolution entity. The administrative fee can be submitted electronically or via mail to the selected dispute resolution entity. The consumer can submit payment in the form of a money order, cashier's check, or electronic third-party payment as specified by the selected dispute resolution entity (such as credit card, debit card, or payment apps). Cash and personal checks are not acceptable forms of payment.

STEP 6c: If necessary, provide additional information to the selected dispute resolution entity.

6c

The selected dispute resolution entity will review the dispute resolution initiation form to see if the consumer is eligible to use the patient-provider dispute resolution process. The dispute resolution entity will reach out to the consumer if more information is needed. The consumer or their authorized representative must respond to a request for additional information with the requested information **within 21 calendar days**.

6d

For more information about conflicts of interest, see the regulations: [Requirements Related to Surprise Billing: Part II](#).

STEP 6d: Determine if the consumer has a conflict of interest with the selected dispute resolution entity.

6d

Once the selected dispute resolution entity determines the consumer is eligible to use the dispute resolution process, it will notify the consumer and the health care provider or facility. If the consumer has a conflict of interest with the selected dispute resolution entity, they can give notice of the conflict when the dispute resolution entity first contacts them. For example, the consumer may be a family member of an employee who works for the entity, and that relationship could prevent the entity from reviewing the case fairly.

If any party (the consumer or the provider or facility) has a conflict of interest with the selected dispute resolution entity, HHS will step in. HHS will select a different dispute resolution entity or otherwise resolve the conflict of interest.

STEP 6e: If applicable, pay any balance due to the provider or facility.

6e

Within **30 business days** of receiving information requested from the provider or facility, the selected dispute resolution entity will decide the final payment amount. The dispute resolution entity will notify the consumer and the provider or facility of its decision and whether the consumer owes a balance.

END

Decision Tree: Patient-Provider Dispute Resolution Process

Frequently Asked Questions

1. What documents are required to initiate the patient-provider dispute resolution process?

There is a \$25 fee to start the dispute process.

The following information is requested to complete the [Patient-Provider Dispute Resolution Initiation Form](#):

- Consumer information
- Details of the dispute
- Provider or facility information (if not included in the good faith estimate): name, email address, phone number, and mailing address
- State where the service was provided
- A copy of the good faith estimate for the item or service to be disputed
- A copy of the bill from the health care provider or facility that is to be disputed
- The last 4 digits of the account number on the bill
- If filing the dispute by mail or fax, the completed [Patient-Provider Dispute Resolution Initiation Form \(en español\)](#).

Most of the information required to complete the form can be found on bills from the provider or facility. If the consumer needs this information, they should contact their provider or facility.

2. What can the consumer expect once they initiate the dispute resolution process?

Generally:

- HHS will select an independent party, called a selected dispute resolution entity, to handle the dispute.
- The selected dispute resolution entity must notify HHS if it has a conflict of interest within 3 business days following selection. Either party may also attest that it has a conflict of interest with the selected dispute resolution entity. If so, the selected dispute resolution entity must notify HHS within 3 business days of receiving the attestation.
- The selected dispute resolution entity will follow up with the consumer if the [Patient-Provider Dispute Resolution Initiation Form](#) is incomplete, if the entity needs more information, or if the item or service is not eligible for dispute resolution. The consumer will have 21 calendar days to submit any requested information.
- The selected dispute resolution entity requests information from the provider or facility. A provider or facility must submit required information to the selected dispute resolution entity within *10 business days* of receiving the entity's selection notice.
- Once the dispute resolution entity receives this information, they have 30 business days to decide the amount that the consumer must pay.

3. What are the consumer protections during the dispute resolution process?

While the dispute resolution process is pending, the provider or facility cannot threaten to take any action against the consumer. The provider or facility cannot move the bill for the disputed item or service into collections nor threaten to do so. If the bill is already in collections, the provider or facility must pause this action. The provider or facility cannot collect any late fees on unpaid bills until the dispute process has ended. If the consumer is having an issue with debt collection, they can submit a complaint with the Consumer Financial Protection Bureau by calling (855) 411-CFPB (2372).

Decision Tree: Patient-Provider Dispute Resolution Process

Frequently Asked Questions

4. What decision can the selected dispute resolution entity make regarding the dispute?

The selected dispute resolution entity must decide the final payment amount for each item or service. The following rules apply:

For any item or service that appears on the good faith estimate:

- If the billed charge for an item or service is less than or equal to the expected charge, the amount to be paid is the billed charge.
- If the billed charge for an item or service is greater than the expected charge and the provider or facility did not provide credible information to justify³ the charges, the amount to be paid is the expected charge.
- If the billed charge for an item or service is greater than the expected charge and credible information is provided to justify the charges, the amount to be paid is the lesser of:
 - The billed charge, or
 - The median payment amount paid by a plan, issuer, or Federal Employee Health Benefits carrier for the same or similar service by a same or similar provider in the geographic area where services were provided that is reflected in an independent database. If the amount in the database is less than the expected charge reflected on the good faith estimate for the item or service, the amount to be paid is the expected charge.

For an item or service that does not appear on the good faith estimate:

- If the provider or facility does not provide credible information to justify the charges, the amount to be paid will be equal to \$0.
- If the provider or facility does provide credible information to justify the charges, the amount to be paid will be the lesser of:
 - The billed charge, or
 - The median payment amount paid by a plan, issuer, or Federal Employee Health Benefits carrier for the same or similar service, by a same or similar provider in the geographic area that is reflected in an independent database.

Note: Some consumers may receive [abbreviated good faith estimates](#), which do not list any items and services. These estimates can be furnished in instances where providers and facilities expect to provide care at no cost to a consumer. HHS guidance strongly encourages selected dispute resolution entities to take into account that the provider indicated they did not intend to bill the consumer for any items or services.

The selected dispute resolution entity will inform both parties of the decision as soon as feasible.

5. What happens if the consumer and the provider come to a payment agreement before the dispute process ends?

The consumer and the provider or facility can settle the dispute and agree on a payment amount any time before the dispute resolution entity notifies the parties of a final determination. For example, the provider or facility can offer financial assistance or let the consumer pay a lower amount. The consumer can also agree to pay the billed charges in full.

If the consumer and the provider or facility agree on a payment amount, the bill must be reduced by at least \$12.50 (half of the administrative fee). The provider also must notify the dispute resolution entity that a settlement has been reached.

³ In this context, a charge is justified if the provider or facility provides credible information that the difference between the billed charge and the expected charge for the item or service in the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

Introduction

This document is intended to help consumer advocates in determining whether a consumer received the appropriate notice and consent forms that could allow them to be balance billed. For more information on notice and consent, see [When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use](#) and [No Surprises: Health Care Notice and Consent Form: What to know before you sign](#). For definitions of terms used in this document, refer to the [No Surprises Act Consumer Advocate Toolkit Glossary](#).

The No Surprises Act generally protects consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage through an employer, the Federal Employees Health Benefits Program, the Health Insurance Marketplace¹, or an individual plan purchased directly from an insurance company. For a more complete list of the types of health coverage subject to the No Surprises Act, see [No Surprises Act: Overview of Key Consumer Protections](#).

In certain circumstances, when a consumer receives items or services that are covered by their health plan from an out-of-network provider, out-of-network air ambulance provider, or an out-of-network emergency facility, the No Surprises Act will prohibit surprise billing and limit the consumer's out of pocket costs.

An out-of-network provider or out-of-network emergency facility can ask a consumer to voluntarily give up their legal protections from higher bills for certain services by signing a "notice and consent" form in certain circumstances. For example, consumers may elect to waive their rights in order to see an out-of-network provider such as a specialist. The form furnished by the out-of-network provider or emergency facility must always include a good faith estimate of the charges, as well as certain other information required by law.

A provider or facility can refuse to treat an individual who does not consent to waive their balance billing protections if doing so is allowed under state law. No fees can be imposed on an individual for cancelling an appointment if they don't consent to waive their No Surprises Act protections.

Below is a decision tree for determining when the notice and consent exception applies.

Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>. For more information on contacting the No Surprises Help Desk, see [No Surprises Act: How to Get Help and File a Complaint](#).

State Consumer Assistance Programs (CAPs) may also help with surprise billing questions. To see if your state has a CAP, please visit this [state listing](#).



¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

Decision Tree: Notice and Consent

Notice and consent is permitted in the following cases:

SCENARIO 1: If a consumer schedules certain non-emergency services at an in-network facility from a non-participating provider, and the out-of-network provider or in-network facility follows all requirements for notice and consent, and complies with state laws.²

SCENARIO 2: If a consumer needs care after an emergency medical condition (called post-stabilization care³) and the following are true:

- ✓ The attending emergency physician or treating provider determines that the consumer is stable enough to travel using nonmedical or nonemergency medical transport to an in-network provider/facility located within a reasonable distance, given their medical condition;
- ✓ The consumer or their authorized representative is able to understand the information and provide informed consent (as determined by the attending emergency physician or treating provider using appropriate medical judgment); and
- ✓ The out-of-network provider or facility follows all requirements⁴ for notice and consent and complies with state laws.

Notice and Consent is **NEVER** allowed for:

- Emergency services before a consumer is stabilized.
- Non-emergency ancillary services at an in-network health care facility.

Timing and Method of Delivery Requirements for Notice and Consent Forms:

- The form must be given separately from other forms. It may not be attached to other forms, hidden among other forms, or incorporated into any other documents.
- The form generally must be available in the 15 most common languages in the state or facility service area. Interpreters must be provided to consumers who cannot understand the form.
- The form must be provided on paper or electronically, consistent with the consumer's choice.
- The consumer must receive a copy of the signed form in-person, by mail, or via email, consistent with their choice.
- If a consumer makes an appointment at least 72 hours in advance, the form must be provided at least 72 hours before the date of the appointment.
- If the consumer makes an appointment less than 72 hours in advance, the form must be provided on the day the appointment is scheduled.
- If the consumer makes an appointment on the same day the items or services are scheduled to be provided, the form must be provided at least three hours in advance.



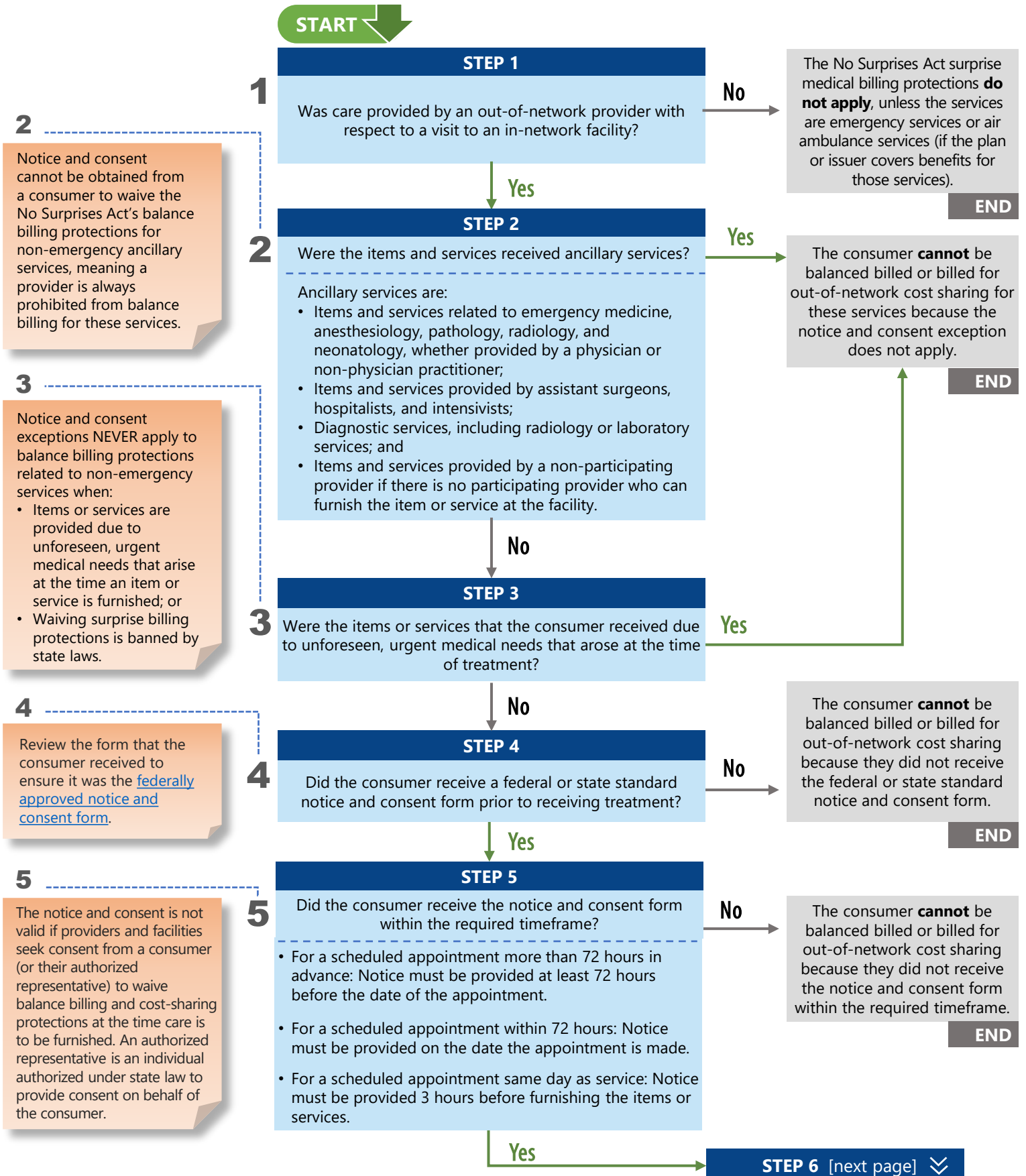
² Notice and consent is not permitted in these circumstances for ancillary and certain other services or for items or services provided due to unforeseen urgent medical needs in the course of care delivery.

³ Emergency services include any additional items and services that are covered under a plan or coverage after a participant, beneficiary, or enrollee is stabilized (referred to as post-stabilization services) and that are furnished as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the pre-stabilization services are furnished, unless certain notice and consent requirements are met. The notice and consent exception to post-stabilization services does not apply to services furnished as a result of unforeseen, urgent medical needs that arise at the time a post-stabilization service is furnished.

⁴ Requirements as defined in "Requirements Related to Surprise Billing; Part 1," Federal Register 86, No. 131 (July 13, 2021): 36872; §149.410(b)-(d) <https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf>.

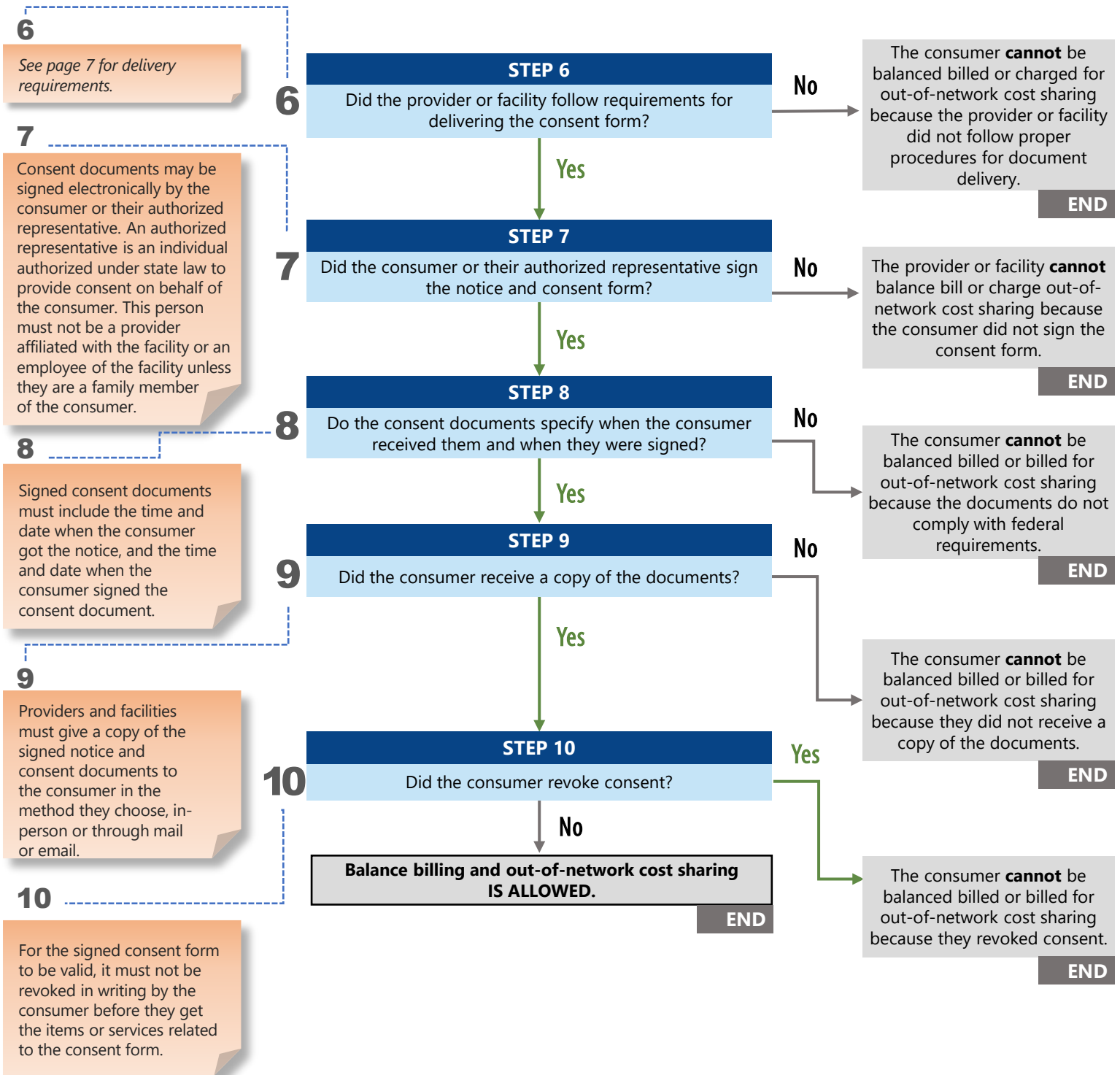
Decision Tree: Notice and Consent

Scenario 1: Notice and Consent Exceptions for Non-Emergency Services



Decision Tree: Notice and Consent

Scenario 1: Notice and Consent Exceptions for Non-Emergency Services



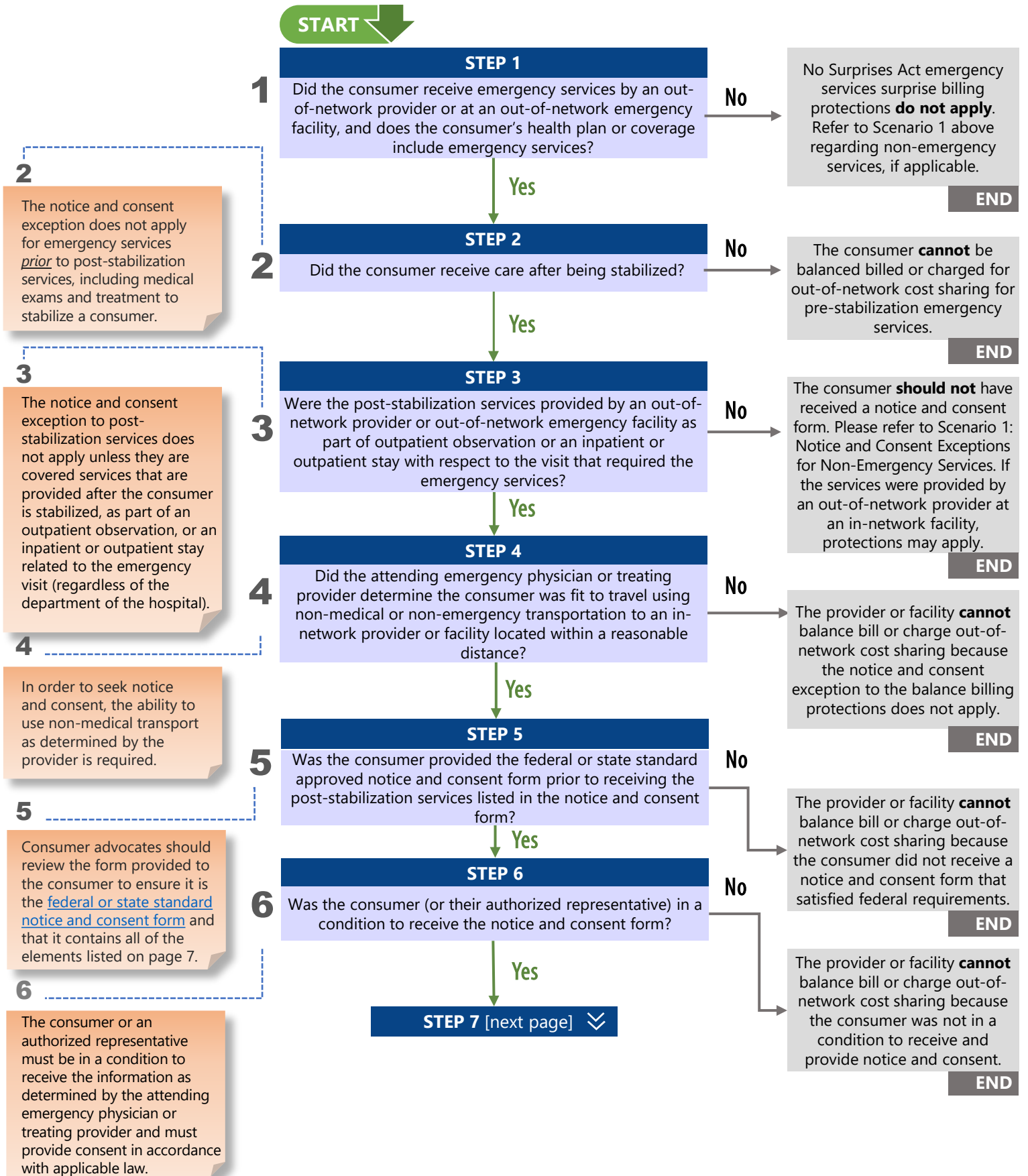
Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: <https://nsa-idr.cms.gov/consumercomplaints>. For more information on contacting the No Surprises Help Desk, see [No Surprises Act: How to Get Help and File a Complaint](#).



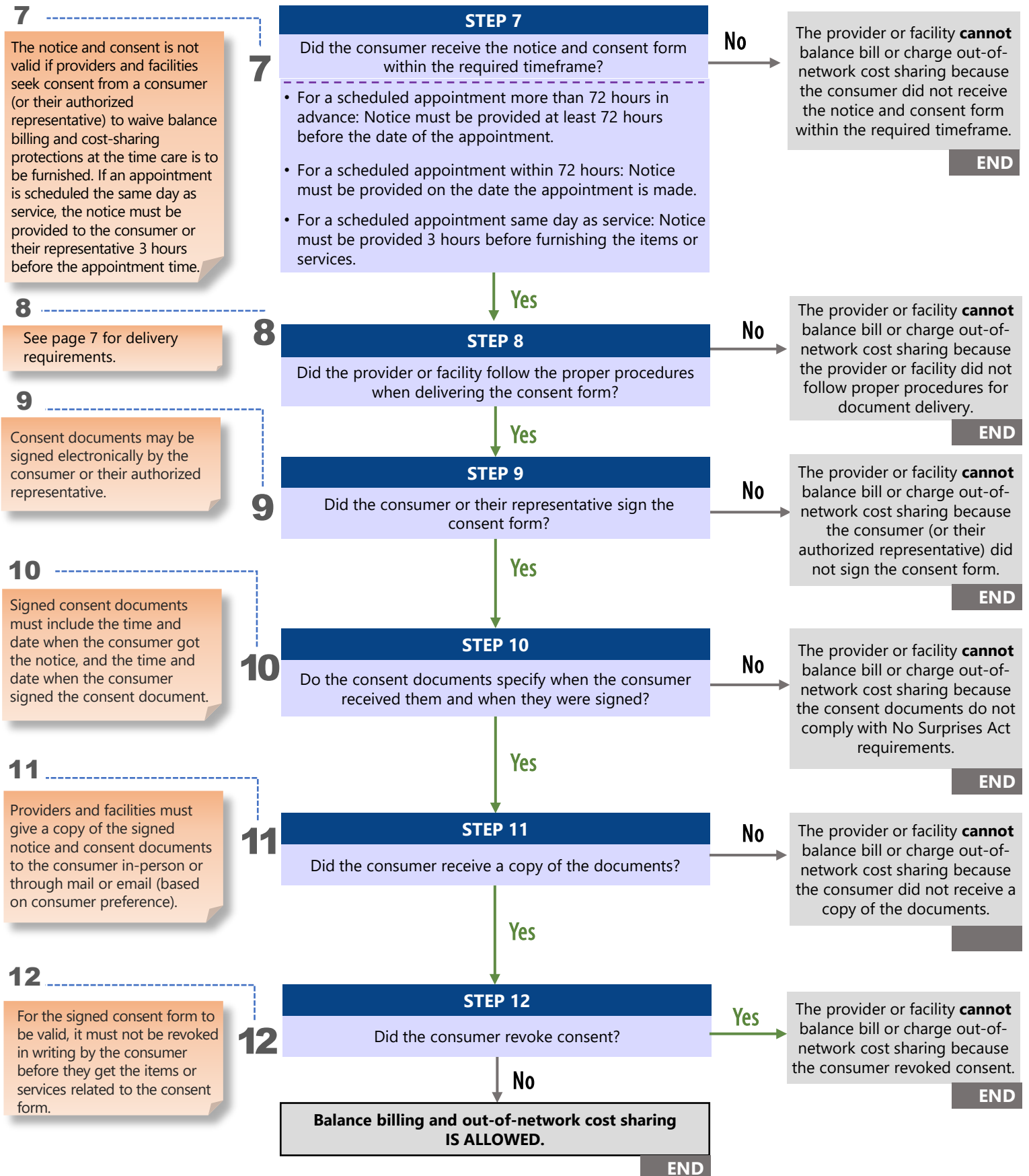
Decision Tree: Notice and Consent

Scenario 2: Notice and Consent Exception for Emergency Condition Post-Stabilization Services



Decision Tree: Notice and Consent

Scenario 2: Notice and Consent Exception for Emergency Condition Post-Stabilization Services



Decision Tree: Notice and Consent

How Notice and Consent Forms Must Be Delivered:

- ❑ Must be delivered together. They cannot be attached or incorporated into other documents or hidden among other forms.
- ❑ Must be delivered in the method preferred by the consumer (either on paper or electronically).
- ❑ Must generally be available in the 15 most common languages in the state or a facility's geographic service region. If the individual's preferred language is not among the 15 most common languages and the consumer can't understand any of the languages in which the notice and consent documents are provided, they can't give consent unless a provider or facility provides a qualified interpreter to get consent.

What Notice and Consent Forms Must Contain:

- ❑ Consumer Name
- ❑ Out-of-network provider(s) or facility name
- ❑ Statement that the health care provider is an out-of-network provider, with respect to the health plan or coverage
- ❑ Good faith estimates of the amount the consumer may be charged for items or services delivered by the out-of-network provider(s) or facility
- ❑ Statement that prior authorization or other care management limitations may be required
- ❑ For post-stabilization services furnished by an out-of-network provider in an in-network emergency facility: A list of in-network providers at the facility able to deliver needed items or services.



Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>. For more information on contacting the No Surprises Help Desk, see [No Surprises Act: How to Get Help and File a Complaint](#).



3. How to Take Action

[GO BACK TO TOC](#)



Helping Consumers Protect Their Rights Under the No Surprises Act



The No Surprises Act protects consumers against surprise medical bills and provides other key consumer protections under federal law. [See [No Surprises Act: Overview of Key Consumer Protections](#).] This document explains steps that a consumer or consumer advocate can take if they believe that a health care provider or facility, air ambulance provider, health plan, or insurer has not complied with the No Surprises Act protections.

In addition to taking the actions described below, a consumer (or their representative) may file a complaint with the No Surprises Help Desk at 1-800-985-3059, or submit a complaint online at: <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>.

See [No Surprises Act: How to Get Help and File a Complaint](#) for more information. All complaints will be reviewed and, if appropriate, referred to the correct enforcement authority. Depending on the type of complaint, these authorities could include state agencies (such as state departments of health, insurance, or other agencies) or federal agencies including:

- The Centers for Medicare & Medicaid Services within the Department of Health and Human Services;
- The Department of Labor;
- The Department of the Treasury; or
- The Office of Personnel Management.

If enforcement authorities determine that a health care provider or facility, air ambulance provider, health plan, or insurer has not complied with the No Surprises Act protections, the appropriate federal or state agency may be able to help consumers fix an erroneous provider bill or correct an improperly processed insurance claim. Specific actions taken by enforcement agencies to solve a compliance problem may vary by state. If No Surprises Act consumer protections were not properly applied when the initial claim or bill was generated, enforcement agency actions may result in lower out-of-pocket costs for the consumer.

While the No Surprises Act provides new federal protections for consumers, state laws also may have similar or even stronger protections. For example, a state law may prohibit surprise bills for ground ambulance services, which are not covered under the federal law. State laws may also specify how to calculate consumer cost sharing. For more detailed information on state laws and the No Surprises Act, see [State Surprise Billing Laws and the No Surprises Act](#) and [Questions and Answers on the No Surprises Act and State Laws](#). Consumer advocates should research any state laws that may apply to a consumer's situation.

Helping Consumers Protect Their Rights Under the No Surprises Act

Action Scenarios

Below are some situations under the No Surprises Act that may need action to resolve them.

NOTE: These examples assume that no state law applies.

Scenario **1**

Non-Compliance With Surprise Billing Requirements

A provider or facility sends a consumer a surprise bill that is prohibited under the No Surprises Act.

Scenario **5**

Bill for Insured Consumer Exceeds Good Faith Estimate

An insured consumer receives a good faith estimate as part of the notice and consent form they signed to waive their surprise billing protections. The consumer later receives a bill from a provider that is more than the estimate.

Scenario **2**

Non-Compliance With Notice and Consent Requirements

A consumer is asked to waive their surprise billing protections in a way that is prohibited by the No Surprises Act.

Scenario **6**

Non-Compliance with Continuing Care Requirements

An in-network contract between a provider and a health plan ends (for reasons other than failure to meet certain quality standards or fraud) or the provider is no longer considered in-network. As a result, coverage under in-network rules is discontinued for an enrollee who is considered to be a continuing care consumer as defined under the No Surprises Act.

Scenario **3**

Non-Compliance With Good Faith Estimate Requirements

A provider did not comply with requirements for providing good faith estimates for an uninsured (or self-pay) individual.

Scenario **7**

Non-Compliance With PPDR Determination

A consumer's bill is not adjusted by a provider or facility after a Patient-Provider Dispute Resolution entity determines that the bill should be reduced.

Scenario **4**

Bill for Uninsured Consumer Exceeds Amount of Good Faith Estimate

An uninsured or self-pay consumer receives a good faith estimate from a provider or facility. The provider or facility completed all of the requirements under the No Surprises Act for furnishing the estimate. However, the provider or facility sends the consumer a bill that is higher than the amount on the estimate.

Scenario **8**

Non-Compliance With Provider Directory Requirements

A health plan's provider directory was not updated in the timeframe required under law. A consumer who relied on the directory inadvertently received care for covered services from a provider who was no longer in-network.

Helping Consumers Protect Their Rights Under the No Surprises Act

Scenario

1



**Non-Compliance
With Surprise Billing
Requirements**

A provider or facility sends a consumer a surprise bill that is prohibited under the No Surprises Act.

Example:

A consumer with coverage under an employer-based group health plan receives emergency services at a local hospital emergency department from a physician who is not in-network with the consumer's health plan. The provider sends a claim for payment to the health plan, which covers emergency services. Later, the consumer receives either:

- A balance bill from the provider that is higher than the in-network cost-sharing amount reflected on the health plan's Explanation of Benefits (EOB), or
- An EOB from the health plan, and a balance bill from the provider, each indicating that the consumer's cost sharing may have been calculated using the plan's out-of-network cost-sharing requirements.

What You Can Do

In these circumstances, consumer advocates will need to gather information to try to determine how the health plan calculated the cost-sharing amount reflected on the EOB and how the provider calculated the bill. Advocates should then compare this information to the No Surprises Act requirements to make sure the health plan and provider followed the processes required under the law.

Step 1:

Review the EOB and the bill.

- Verify that the following are accurate: consumer's name, consumer's health plan policy number and provider account number, and dates of service.
- Compare the EOB for the services received against the provider's bill to confirm that furnished items and services match.
- Identify any discrepancies in the items and services provided, including their corresponding procedure, site of service, and/or billing codes.
- Identify any duplications of items and services.



Note: Look for language indicating that the claim is subject to the No Surprises Act. For example, the EOB may include information indicating that No Surprises Act protections apply and could include a statement that the cost sharing is calculated based on the [qualifying payment amount](#). NOTE: Absence of this language does not mean the No Surprises Act does not apply.

Helping Consumers Protect Their Rights Under the No Surprises Act

Note the provider, facility, or provider of air ambulance services may also have information on how the cost sharing was calculated.

Step 2:

Determine if the No Surprises Act applies.

- Consult the [Decision Tree: No Surprises Act Federal Surprise Billing Protections](#).
- Request the information outlined under the “Documents Needed” section.
- Review the following sections of the Decision Tree based on the information provided and conversations with the consumer:
 - The initial screening questions, and
 - The screening questions in section A, B, or C, depending on the type of items and services the consumer received. (For this example, review Section A, the emergency items and services screening questions.)



IMPORTANT: If the No Surprises Act applies, the consumer’s cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer’s costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

For emergency services, the health plan cannot place any limits on coverage that are more restrictive than if the provider was in-network. (This is true regardless of the state in which the items and services were received.)



Helping Consumers Protect Their Rights Under the No Surprises Act

Step 3:

Share your findings with the provider and, if appropriate, the health plan.

- Ask the provider to review the bill, taking this information into account.
- Ask the health plan to recalculate the consumer's cost sharing if you believe the EOB reflects an incorrect cost-sharing amount. If after speaking with the health plan, you think the health plan is not correctly processing the claim, file an internal appeal. The Explanation of Benefits (EOB) should provide information on how the claim was processed and the reason a claim may have been denied.
- You may also file a complaint with the No Surprises Help Desk if you believe either the health plan or the provider is not correctly calculating the consumer's cost sharing.



After the consumer's cost sharing is correctly calculated, ensure that the paid amount is applied to the consumer's in-network deductible and maximum out-of-pocket limit. This may require additional follow-up with the health plan or the No Surprises Help Desk.



How Bills Should Be Calculated

The No Surprises Act specifies how a consumer's cost sharing from an out-of-network provider should be calculated in instances where the No Surprise Act billing protections, and not state law surprise billing protections or an All-Payer Model Agreement, apply.

- The cost sharing generally should be based on the lesser of the billed charge or the health plan or issuer's qualifying payment amount, which is generally based on the median contracted rate for the same or similar item or service in the same geographic area. The health plan sends this information and other required information to the provider, facility, or provider of air ambulance services when sending a payment or notice of denial of payment.

The consumer's cost-sharing requirement may not be more than the in-network cost-sharing requirement for the same item or service. For example, if the in-network cost sharing for emergency services is 20%, the consumer cost sharing for out-of-network emergency services cannot be greater than 20%.

For more information on cost-sharing calculations, see [No Surprises Act: Overview of Key Consumer Protections](#).

Helping Consumers Protect Their Rights Under the No Surprises Act



A consumer is asked to waive their surprise billing protections in a way that is prohibited by the No Surprises Act.

Example A:

A consumer with employer-based group health coverage is asked to waive their surprise billing protections for an ancillary service associated with a scheduled (non-emergency) procedure at an in-network hospital. For example, a week before a scheduled surgery, an out-of-network radiologist asks a consumer to sign a consent form to allow balance billing for radiology services that will be provided during the procedure.

What You Can Do

Step 1:

Consult the [Decision Tree: Notice and Consent](#) for information on when a provider may ask a consumer to waive their federal surprise billing protections.

Step 2:

In situations where it appears that a provider or facility has asked a consumer to waive their surprise billing protections when doing so is prohibited, such as for the [ancillary services](#) (radiology services) in this example:

- Tell the provider that the No Surprises Act prohibits waiving of surprise billing rights in this situation. Providers may never seek a consumer's consent to waive the No Surprises Act surprise billing protections for non-emergency ancillary services.
- If the consumer has not yet undergone surgery, the consumer can revoke any consent they have signed. If they have not signed a consent form, the consumer may request a written assurance that the consumer will not be balance billed for the radiology services (although federal law does not require a provider to respond). However, even if the consumer takes no action, the radiology provider is not permitted to balance bill because the notice and consent exception to the balance billing protection does not apply to ancillary services such as radiology services.



Helping Consumers Protect Their Rights Under the No Surprises Act

- If the consumer has undergone surgery and receives a balance bill from the provider, inform the provider that they cannot balance bill because the surprise billing protections under the No Surprises Act apply and cannot be waived. Tell the provider they should file a claim with the consumer's health plan or insurer if they have not already done so. The provider should use the information provided by the health plan to calculate the correct amount that the consumer may be billed.
- If the provider continues to pursue payment from the consumer, file a complaint with the No Surprises Help Desk. The Help Desk may ask you to share relevant information about why you think the provider is not complying with the No Surprises Act. Therefore, it is important to document your findings as you work with the consumer.
- If the consumer is having an issue with debt collection, consider filing a complaint with the Consumer Financial Protection Bureau by calling (855) 411-CFPB (2372).

Example B:

A consumer with individual coverage purchased on the Health Insurance Marketplace¹ is asked to waive their surprise billing protections by an out-of-network provider. The provider does not follow the proper notice and consent procedures. For example, an out-of-network head surgeon asks a consumer to waive their protections for an upcoming procedure at an in-network ambulatory surgical center. However, the delivery method, timing, or content of the notice and consent form does not meet requirements under the No Surprises Act.

What You Can Do

Step 1:

Consult the [Decision Tree: Notice and Consent](#) for information on the requirements providers must follow related to the notice and consent process.

Step 2:

- If the consumer has not yet received the items or services: If the provider refuses to provide the scheduled items and/or services unless the consumer signs the form, then the provider cannot charge the consumer for canceling the appointment. Be aware that a provider can refuse to treat a consumer who refuses to sign the consent form unless state law says otherwise.
- If the consumer receives the services and later receives a balance bill for out-of-network charges: Contact the provider to explain that they cannot balance bill because the balance billing protections under the No Surprises Act apply and were not properly waived. The No Surprises Act protections apply as though the consumer did not sign the consent form and the consumer cost sharing should be calculated accordingly. The provider should file a claim with the consumer's health plan if they have not already done so. The provider should use the information provided by the health plan to calculate the amount that the consumer may be billed.

If needed, contact the health plan or insurer to ensure the final cost-sharing amount is correctly applied to the consumer's in-network deductible and maximum out-of-pocket limit.

¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.



Helping Consumers Protect Their Rights Under the No Surprises Act



A provider did not comply with requirements for providing a good faith estimate for an uninsured (or self-pay) individual.

Example:

An uninsured or self-pay consumer either:

- Did not receive a good faith estimate; or
- Received an estimate, but it:
 - Was not provided in clear and understandable language;
 - Was not provided within the required timeframe;
 - Was not provided in the manner requested by the consumer (paper or electronically); or
 - Did not include all required information.



What You Can Do

Step 1:

Consult the [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#) for more information on requirements related to estimates.

Step 2:

If you believe that a provider did not follow these requirements, contact the provider to explain your concerns. Depending on the circumstance, you could:

- Ask why an estimate was not provided. Generally, uninsured and self-pay consumers should receive a good faith estimate when they request one or upon scheduling an appointment three or more days in advance.
- Describe any problems you see with the estimate or how it was provided. If applicable, explain how these issues caused confusion about the final cost of an item or service.
- If relevant, request that the provider or facility re-calculate the bill based on these concerns. For example, if an item or service that was expected to be provided was not included on the estimate, the final bill should not include a charge for that service.

Helping Consumers Protect Their Rights Under the No Surprises Act



An uninsured or self-pay consumer receives a good faith estimate from a provider or facility. The provider or facility completed all of the requirements under the No Surprises Act for furnishing the estimate. However, the provider or facility sends the consumer a bill that is higher than the amount on the estimate.

What You Can Do

Step 1:

Consult the [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#) for more information about good faith estimates.

Step 2:

Contact the provider to ask why the bill is higher than the estimate. NOTE: The good faith estimate is not required to include charges for unanticipated items or services that could not reasonably have been foreseen by the provider at the time the estimate was created (e.g., in the case of medical complications).

If you still believe that the bill is not correct, you may:

- Ask the provider or facility to modify the bill to match the estimate;
- Try to negotiate a lower price; or
- Ask if financial assistance is available.

If the bill from a single provider or facility is at least \$400 more than the amount reflected on the estimate for that provider or facility, the consumer may use the [Patient-Provider Dispute Resolution process](#).

Helping Consumers Protect Their Rights Under the No Surprises Act

Scenario

5

Bill for Insured Consumer Exceeds Good Faith Estimate



An insured consumer receives a good faith estimate as part of the notice and consent form they signed to waive their surprise billing protections. The consumer later receives a bill from a provider that is more than the estimate.

What You Can Do

Contact the provider to try to negotiate a better price. A good faith estimate provided as part of the notice and consent form is not eligible for review through the Patient-Provider Dispute Resolution process.

Scenario

6

Non-Compliance with Continuing Care Requirements



An in-network contract between a provider and a health plan ends (for reasons other than failure to meet certain quality standards or fraud) or the provider is no longer considered in-network.

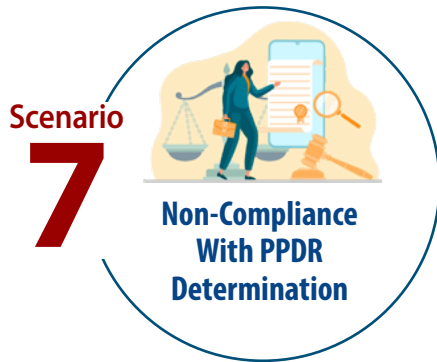
As a result, coverage under in-network rules is discontinued for an enrollee who is considered to be a continuing care consumer as defined under the No Surprises Act.* The consumer would need to switch providers in the middle of treatment to have additional services covered under in-network rules.

What You Can Do

- Ask the consumer if they were notified by their health plan that the provider was no longer in-network and that the consumer could elect to receive continued transitional care from that provider for up to 90 days under in-network rules. If not, contact the health plan to explain that the No Surprises Act continuity of care requirements might not have been followed.
- Ask the health plan to provide notification as required under the No Surprises Act to enable the consumer to opt to receive continued care under in-network rules. This will allow the provider to be reimbursed at the previous contract rate for up to 90 days following the consumer's notification by their health plan (unless the consumer is not considered a continuing care patient). The consumer cost sharing should also be calculated based upon the previous in-network level.

*See the [No Surprises Act: Overview of Key Consumer Protections](#) for a description of who is eligible for continuing care under the No Surprises Act.

Helping Consumers Protect Their Rights Under the No Surprises Act



A consumer's bill is not adjusted by a provider or facility after a Patient-Provider Dispute Resolution entity determines that the bill should be reduced.

What You Can Do

In addition to contacting the No Surprises Help Desk, a consumer can contact the provider directly and ask them to adjust the bill to match the amount in the Patient-Provider Dispute Resolution determination.



A health plan's provider directory was not updated in the timeframe required under law.

A consumer who relied on the directory inadvertently received care for covered services from a provider who was no longer in-network. The provider billed the consumer for more than what the in-network cost sharing would otherwise have been.

What You Can Do

- Contact the health plan to request that the cost-sharing amount be reduced to the in-network level and that the subsequent payment should be applied to the in-network deductible or out-of-pocket maximum. You could also contact the provider to request adjustment of the bill.
- If the consumer paid the bill, the provider should reimburse the consumer for the amount in excess of the in-network cost-sharing amount, plus interest, if the provider directory requirements were violated.



No Surprises Act

How to Get Help and File a Complaint



The No Surprises Help Desk provides a phone line and web-submission process for people who have questions about the No Surprises Act or want to report what they think is a violation of the No Surprises Act’s rules.

The **Help Desk** can help consumers, their authorized representatives, and health care providers. If you call the Help Desk, a live person can help you with:

- **Concerns** about medical billing protections, such as balance or surprise medical bills.
- **Complaints** that the requirements of the No Surprises Act are not being followed.
- **General questions** about the protections and requirements of the No Surprises Act.

The **Consumer Complaint Form** is an online form for reporting potential violations of the No Surprises Act. Both the Help Desk phone line and the Consumer Complaint Form can assist in answering your questions and may lead to a referral to the right federal or state agencies for more help.

What the No Surprises Help Desk can do

- Review the complaint to determine if the health insurance company, health plan, health care provider, health care facility, or air ambulance provider followed surprise billing rules.
- Investigate complaints about compliance with federal laws under the Centers for Medicare and Medicaid Services' (CMS) jurisdiction.
- When appropriate, refer the complaint to an applicable federal or state enforcement authority, which could determine if the provider or facility must adjust their charges.
- Try to find patterns of problems that may need further review.
- Help consumers understand what documentation they should submit or what next steps they should take.
- Help answer questions or direct the consumer to someone who can.
- Connect consumers with a local Consumer Assistance Program (CAP), where available, for additional help.

What the No Surprises Help Desk can't do

- Act as a lawyer or give legal advice.
- Make medical judgments or determine if further treatment is necessary.
- Address issues that CMS can't legally enforce.



What to expect when calling the No Surprises Help Desk or using the Consumer Complaint Form

You will need to provide the Help Desk or Consumer Complaint Form with contact information for yourself and any parties to the complaint, a detailed description of their issue(s), and any action(s) they've previously taken to resolve their issue(s).

1

The No Surprises Help Desk may also ask for supporting documentation, like medical bills and Explanations of Benefits that can assist in the review of the complaint. However, you don't need to submit anything before calling the Help Desk or submitting the Consumer Complaint Form.

Note: The No Surprises Help Desk encourages consumers to submit all documentation that may assist in the review of their complaint or inquiry.

2

After contacting the Help Desk or submitting the Consumer Complaint Form, you will get a confirmation email explaining next steps. You may also get a request for additional information or documentation the Help Desk will need to review the complaint.

3

You'll get a phone call or email with the results of the review. This review will include next steps and may also include referrals to federal or state agencies for assistance.

4

To check on the status of a complaint, or to see what documentation may be needed, you can also call the No Surprises Help Desk.

What to know about referrals to other agencies or organizations

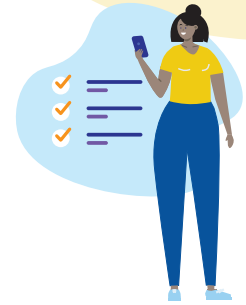
The No Surprises Help Desk may refer you to other agencies or organizations for assistance. This could include federal or state agencies who have jurisdiction over a consumer's complaint or inquiry. For example, some states have their own balance billing protections and processes.

The No Surprises Help Desk may also refer you to a state CAP to help resolve problems with health insurance or to learn about health coverage options. To see if your state has a CAP, please visit [this state listing](#).

You may follow-up with the No Surprises Help Desk if you have been referred to another agency or organization and have not heard back from that agency or organization. You can also call the No Surprises Help Desk if you were referred to the wrong place.

No Surprises Act

How to Get Help and File a Complaint



Checklist: What Documents to Have On Hand

Be prepared to provide detailed information about the issue. If possible, have these documents on hand:

Key Documents

- Health insurance card(s)** if the consumer is insured.
- Information on whether the consumer's plan is a self-insured plan (the consumer can call the employer's benefits office or the health insurance company to find out).
- Information about any **gaps in health coverage**, especially if they overlap with the dates of service.
- Medical bills**.
- Explanation of Benefits** statements.

Other Helpful Information

- Consent forms** the consumer or their representative may have signed waiving their balance billing protections.
- Good faith estimates** from health care providers or facilities, if any.
- Correspondence** the consumer or their authorized representative has had with their health care provider, facility, air ambulance provider, insurance company, health plan, or state or federal agency concerning billing disputes. All correspondence should include dates if possible.
- Notes from any phone calls with the health care provider, facility, air ambulance provider, insurance company, health plan, or state or federal agency.
- Records of any related **medical bills the consumer has already paid**, including copays, coinsurance, and deductibles.
- Communications concerning late fees or collection attempts** for medical bills.
- Medical records related to the item(s) or service(s), such as discharge summaries.
- Documentation authorizing a representative to communicate on the consumer's behalf (if available, not required).
- Information posted on the provider or facility's website outlining **surprise billing protections**, including state and federal agency contact information.
- Summary Plan Description** or **certificate of coverage**.

How to access the No Surprises Help Desk and Consumer Complaint Form

If you are a consumer advocate or other individual helping consumers with questions about the No Surprises Act, you may refer the person you are helping directly to the Help Desk or the Consumer Complaint Form. You may also use these resources yourself if acting on someone's behalf.

Note: The consumer must provide a verbal authorization to the Help Desk the first time you call on their behalf.

Call the No Surprises Help Desk at 1-800-985-3059.
Submit a complaint online at
<https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>.



Tips for Using the No Surprises Consumer Complaint Form



Be Prepared and Know What to Expect

The [No Surprises Consumer Complaint Form](#) allows consumers to report potential violations of the [No Surprises Act](#) online. The form is managed by the [No Surprises Help Desk](#) at the Centers for Medicare & Medicaid Services (CMS). Consumers can use the form to submit questions and get referrals for additional assistance. For more information about the No Surprises Help Desk, please see the companion resource [No Surprises Act: How to Get Help and File a Complaint](#).

The screenshot shows the CMS.gov website interface. At the top, there are navigation links for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. A search icon is also present. Below the navigation is a breadcrumb trail: Home > Medical bill rights > Get help. A secondary navigation bar includes Home, Know your rights, Get help, and Cambiar a Español. The main content area is titled 'You can submit a complaint with us' and contains the heading 'When your provider or insurer might not be following the rules'. Below this heading is a paragraph explaining that health insurance companies and providers must follow rules that protect consumers from unexpected, or 'surprise,' out-of-network bills. It also states that if a question arises or rules aren't being followed, users can submit questions or complaints to the No Surprises Help Desk. On the right side of the page, there is a 'Submit a complaint' box with a 'Get Started' button. Below this box is a link to 'Update an existing complaint' and a phone number for submitting complaints: 1-800-985-3059.

The Complaint Form is often the first step in the process of filing a complaint about potential violations of the No Surprises Act.

The following pages provide tips for filling out certain sections of the form. However, they do not explain each step in the process of filing a complaint. See the [No Surprises Consumer Complaint Form \(file named "CMS-10779. Consumer Complaint Form No Surprises Help Desk.pdf"\)](#) for the full list of questions in the form. NOTE: Questions may be worded differently than in the online form.

Tips for Using the No Surprises Consumer Complaint Form

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Submit a complaint

What issue do you need help with?

*** Choose one of the following options.**
Pick the option that fits your situation best. Or pick "it's something else."

- I received emergency care at a hospital and received a bill from an out-of-network provider.
- I received care at an in-network facility but received a bill from an out-of-network provider.
- I received care within 90 days of my provider leaving my health plan's network, but I was charged at out-of-network rates.
- My provider didn't tell me about my medical billing protections.
- My insurance company is not complying with the Mental Health Parity and Addiction Equity Act (MHPAEA).
- It's something else.

Continue

Tip: Choose the complaint type. Choose the complaint category that best fits most of the issues in the situation.

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Submit a complaint

Who is this complaint against?

Let us know who this complaint is about. Examples include your doctor, hospital, or insurance company.

i Who should I put here?

*** Pick the type of provider this complaint is against.**

- Health Care Provider
- Health Care Facility
- Insurance Company or Plan
- Air-Ambulance Provider
- Other

*** Provider name**

Tip: Who is the complaint about?

- A health care provider (like a doctor, therapist, nurse practitioner)
- A health care facility (like a hospital)
- A health insurance company or group health plan
- An air ambulance provider
- Other

Tips for Using the No Surprises Consumer Complaint Form

Share what happened

To process your complaint, we want to know more about what happened.

* **Tell us about your issue.**

You can enter up to 1024 more characters.

Tip: Provide as much information as possible about the issue and any steps the consumer has already taken.

See some examples below.

What have you done so far to try to resolve this issue?

* **What steps have you taken?**

You can enter up to 500 more characters.

Example Problem Description #1

Share what happened:

I received a bill for a visit to the emergency room of my local hospital. My insurance plan documents say my copay for emergency visits is \$500 after I meet my deductible, which I haven't met. Now, the hospital is charging me \$2,500. I also received an Explanation of Benefits from my insurance that said I would only be responsible for \$500. I did not sign a notice and consent form to waive my surprise billing rights.

What have you done so far to try to resolve this issue?

I called the hospital billing department and my insurance company in June 2022. Both have told me they would look into the charges, but I have not heard back or received any more mail about my bill. I am thinking about filing an appeal with my insurance company.

Example Problem Description #2

Share what happened:

On August 5th I got an injection for my knee pain. I don't have insurance, but my orthopedist gave me an estimate of \$300. I paid that amount when I arrived for the procedure, but two weeks later I got a bill (dated August 19) with a balance of \$550. I called the office to complain, and they said what I received was just an estimate. They still want me to pay the balance. What are my rights?

What have you done so far to try to resolve this issue?

Called the orthopedist's office on August 22nd.



Tips for Using the No Surprises Consumer Complaint Form

Documentation

Provide any documentation that might support your case. You can supply documentation later, if you don't have it handy right now.

Uploading these documents is optional. But they help us understand your issue and review your complaint as fast as possible.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG

Bill(s)

Upload any bills you received from your plan, issuer, air ambulance provider, or health care facility.

[Upload one or more files](#)
Maximum file size: 185 MB

CPT codes

If you see CPT codes on your bill, enter them here. Otherwise, leave this field blank.

Claim(s)

Upload any claims you received from your plan, issuer, air ambulance provider, or health care facility.

[Upload one or more files](#)
Maximum file size: 185 MB

Claim number

If you were given a claim number, enter it here. Otherwise, leave this field blank.

[Continue](#)

[Go back](#)

Tip: Upload as much supporting documentation as possible, such as medical bills or explanation of benefits statements. This will help speed up the complaint process.

If the consumer is missing any documentation, the No Surprises Help Desk staff will call or email to follow up. The consumer can also return and submit more documentation later.

Documentation

Provide any documentation of correspondence. You can supply documentation later, if you don't have it right now.

Uploading documentation is optional. But it helps us understand your issue and review your complaint as fast as possible.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG

Correspondence ⓘ

Upload documentation of any correspondence you had with your plan, issuer, air ambulance provider, or health care facility.

[Upload one or more files](#)
Maximum file size: 185 MB

[Continue](#)

[Go back](#)

[? Need help completing this form?](#)

[Ver en Español](#)

Tips for Using the No Surprises Consumer Complaint Form

Submit a complaint ✕

Tell us about your insurance.

These questions are optional, but answer them if you can.
This information will help us understand exactly what laws apply to you.

Plan Type

* What type of insurance or health plan did you use when you got care?

- Non-Federal government plan
You work for a state or local government or a school district and use their health plan.
- Self-funded group health plan from a private employer
- Federal Employees Health Benefits (FEHB) Plan
- Fully-insured group health plan from private-sector employer
- Individual health insurance plan outside the Health Insurance Marketplace™
- Federal Health Insurance Marketplace™ plan
- State-based Marketplace plan
- Medicaid or the Children's Health Insurance Program (CHIP)
- Faith-Based Plan
- TRICARE
- I'm not sure / Other

[Continue](#)

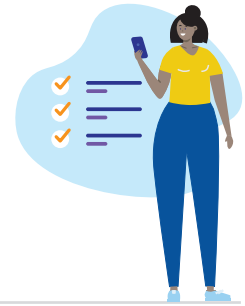
[Go back](#)

Tip: If the consumer is insured, make sure to select the box for the right kind of health coverage, and provide as much information as possible.

If uncertain about the type of coverage, have the consumer contact their employer or health insurance plan.

The No Surprises Help Desk staff can work with the consumer to get any additional information and upload health plan documents.

Tips for Using the No Surprises Consumer Complaint Form



Documents to Have On Hand When Completing the Complaint Form

Be prepared to provide detailed information about the issue. If possible and available, have these documents on hand:

Key Documents

- Health insurance card(s) if the consumer is insured.
- Information on whether the consumer's plan is a self-insured plan (the consumer can call the employer's benefits office or the health insurance company to find out).
- Information about any gaps in health coverage, especially if they overlap with the dates of service.
- Medical bills.
- Explanation of Benefits statements.

Other Helpful Information

- Consent forms the consumer or their representative may have signed waiving their balance billing protections.
- Good faith estimates from health care providers or facilities, if any.
- Correspondence the consumer or their authorized representative has had with their health care provider, facility, air ambulance provider, insurance company, health plan, or state or federal agency concerning billing disputes. All correspondence should include dates if possible.
- Notes from any phone calls with the health care provider, facility, air ambulance provider, insurance company, health plan, or state or federal agency.
- Records of any related medical bills the consumer has already paid, including copays, coinsurance, and deductibles.
- Communications concerning late fees or collection attempts for medical bills.
- Medical records related to the item(s) or service(s), such as discharge summaries.
- Documentation authorizing a representative to communicate on the consumer's behalf (if available, not required).
- Information posted on the provider or facility's website outlining surprise billing protections, including state and federal agency contact information.
- Summary Plan Description or certificate of coverage.

4. State Laws and the No Surprises Act

[GO BACK TO TOC](#)



State Surprise Billing Laws and the No Surprises Act

This document is for consumer advocates and others to use when helping individuals with surprise medical bills. It helps to explain how state laws that protect consumers from surprise medical bills interact with the federal No Surprises Act.



The No Surprises Act created new consumer protections against surprise bills from out-of-network providers (also called non-participating providers) in certain circumstances. These protections generally apply to consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage through an employer, Federal Employees Health Benefits Program, the Health Insurance Marketplace[®],¹ or an individual plan purchased directly from an insurance company.

The No Surprises Act applies to certain types of covered items or services, including:

- Most emergency services (including post-stabilization services);
- Non-emergency items and services furnished by out-of-network providers with respect to a patient visit to certain types of participating health care facilities; and
- Air ambulance services furnished by out-of-network providers of air ambulance services.

Some states have their own surprise billing laws that protect consumers against surprise medical bills. Consumer advocates should review the following resources to explore if a state's surprise billing law applies, either in part or in whole, to a consumer's complaint:

- [State Insurance Agency websites](#)
- [The Commonwealth Fund's Map of State Balance Billing Protections](#)
- [Consumer Assistance Programs](#) (in some states)

Keep in mind that some states are updating their state laws to align more closely with the No Surprises Act.

What's Important to Know:

- Some states have their own surprise billing laws.
- State surprise billing laws may cover different health care items and services than the No Surprises Act.
- Some state laws may have stronger consumer protections than the No Surprises Act.
- Some state laws have their own provider payment formulas or methods for determining patient cost-sharing amounts for the same out-of-network items and services that are also subject to the No Surprises Act. In these states, a patient's cost sharing for out-of-network services may be based on an amount calculated under state law.
- It is important to determine whether a state law may apply to a consumer complaint before disputing a bill under the No Surprises Act or reporting a No Surprises Act violation. The [No Surprises Help Desk](#) can help determine whether state law applies.

¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

State Surprise Billing Laws and the No Surprises Act

When Do State Laws Apply?

The No Surprises Act supplements state surprise billing law protections; it does not replace them. For example, a consumer may receive a surprise bill in a state that has a surprise billing law. If that state law applies to the consumer's bill and provides at least the same level of consumer protection as the No Surprises Act, the state law will generally apply. However, if the state law does not apply to the consumer's bill or only applies in part, and the federal protections do, the consumer can pursue their rights under the federal protections where those protections apply.

In order for a consumer's complaint to be subject to state law, any such law must at least apply to:

- **The plan or issuer:** The state law must apply to the type of health coverage the patient has;*
- **The out-of-network provider or out-of-network emergency facility involved:** The provider or facility that treated the patient must be subject to the state law; and
- **The item or service involved:** The state law must cover the items and services the patient received.

**This analysis should include whether the consumer is enrolled in a self-insured group health plan that opted into state law. State surprise billing laws generally do not apply to self-insured group health plans sponsored by a private employer. However, the [Employee Retirement Income Security Act \(ERISA\)](#) does not prevent state laws from allowing self-insured, ERISA-covered plans to choose to voluntarily comply with them.*

When reviewing a complaint about a medical bill, consumer advocates will need to determine:

1. If a consumer received services in a state with its own surprise billing state law;
2. If the consumer's complaint (including the type of plan, type of provider or facility, and item or service involved) is covered under that state law; and,
3. If the state law is a "specified state law," meaning the state law has its own method to determine patient cost sharing and the out-of-network rate to be paid to a provider or facility.²

Determining the Consumer Cost-Sharing Amount

A state may have a "specified state law" or an [All-Payer Model Agreement](#) that applies with respect to the consumer cost-sharing amount for the types of emergency services and certain non-emergency services covered by the No Surprises Act.

As mentioned above, a "specified state law" is a state law that provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage offered by a health insurance issuer to a non-participating provider or non-participating emergency facility.

In cases where a specified state law applies, the out-of-network payment rate for items and services and the amount upon which patient cost sharing is based are calculated according to the method provided under the specified state law. Where an All-Payer Model Agreement applies, the out-of-network rate and patient cost sharing for the items and services provided are determined under the state approved agreement.

In circumstances where a specified state law or All-Payer Model Agreement does not apply to determine

² Regarding air ambulance services, given the applicability of the Airline Deregulation Act of 1978, the Departments are not aware of any state laws that would meet the criteria to set the out-of-network rate for nonparticipating providers of air ambulance services when providing services subject to the protections in the No Surprises Act. See <https://www.federalregister.gov/d/2021-14379/p-132>.



State Surprise Billing Laws and the No Surprises Act

the cost-sharing amount, and in all circumstances related to the cost sharing for air ambulance services, cost sharing must be based on the lesser of:

- The amount billed by the provider or facility; or
- The Qualified Payment Amount (QPA) for the item or service, which is generally the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

Keep in mind that under the No Surprises Act, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the item or service was provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages. This is true regardless of whether an All-Payer Model Agreement or state law applies to determine cost sharing. For more information on how to calculate cost sharing under these circumstances, see [No Surprises Act: Overview of Key Consumer Protections](#).

Both Federal and State Law Could Apply to a Single Episode of Care

State surprise billing laws do not always cover the same health care items or services, health insurance issuers and health plans, and providers and facilities as the No Surprises Act. In some cases, both the federal No Surprises Act and a state law may apply, but to different items or services within a single episode of care. For example, a state surprise billing law may apply to labor and delivery services, but not to neonatologists. In this case, assuming the No Surprises Act otherwise applies, the No Surprises Act would determine the cost-sharing amount for the neonatology services, while state law would apply to the labor and delivery services.

State laws might differ from the federal No Surprises Act in terms of their definitions of emergency services. The No Surprises Act includes post-stabilization services within its definition of emergency services. Many state laws do not. In a state in which the law does not include post-stabilization services, the No Surprises Act emergency services protections apply to post-stabilization services.



You may also call the Help Desk at 1-800-985-3059 for assistance in determining whether state law applies and how to calculate a consumer's cost-sharing amount.

State Surprise Billing Laws and the No Surprises Act

Examples

The following examples illustrate how state laws may or may not apply.

Example 1

A health insurance issuer licensed in State A covers a specific non-emergency service that is provided to an enrollee by a non-participating provider in a participating health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by non-participating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided.

In Example 1, State A's law would prohibit balance billing and would apply to determine the cost-sharing amount and the out-of-network rate.

Example 2

Same facts as Example 1, except that the non-participating provider and participating health care facility are located and licensed in State B. State A's law does not apply to the provider, because the provider is licensed and located in State B.

In Example 2, State A's law would not apply to prohibit balance billing or to determine the cost-sharing amount or out-of-network rate. Instead, balance billing would be prohibited under the federal No Surprises Act, and the lesser of the billed amount or QPA would apply to determine the cost-sharing amount.



Example 3

A self-insured plan, subject to ERISA, covers a specific non-emergency service that is provided to a participant by a non-participating provider in a participating health care facility, both of which are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by non-participating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. State A's law applies to health insurance issuers and providers licensed in State A and provides that plans that are not otherwise subject to State A's law may opt in. State A's law also applies to the type of service provided. The self-insured plan has opted into State A's law.

In Example 3, State A's law would apply to prohibit balance billing and determine the cost-sharing amount and the out-of-network rate.

State Surprise Billing Laws and the No Surprises Act

Example 4

An individual receives emergency services at a non-participating hospital located in State A. The emergency services furnished include post-stabilization services. The individual's coverage is through a health insurance issuer licensed in State A, and the coverage includes benefits with respect to services in an emergency department of a hospital. State A has a law that prohibits balance billing for emergency services provided to an individual at a nonparticipating hospital located in State A and provides a method for determining the cost-sharing amount and total amount payable in such cases. The State A law applies to issuers licensed in State A. However, State A's law has a definition of emergency services that does not include post-stabilization services.

In Example 4, State A's law would apply to prohibit balance billing and determine the cost-sharing amount and out-of-network rate for the emergency services, as defined under State A's law. State A's law would not apply for purposes of prohibiting balance billing and determining the cost-sharing amount and out-of-network rate for the post-stabilization services. Instead, balance billing would be prohibited under the federal No Surprises Act and the lesser of the QPA or billed amount would apply to determine the cost-sharing amount for the post-stabilization services.

Example 5

A community-rated Federal Employee Health Benefits plan covers a specific non-emergency service that is provided to a covered individual in State A by a nonparticipating provider in a participating health care facility. Both the provider and the facility are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by non-participating providers in a participating health care facility and provides for a method for determining the cost-sharing amount and total amount payable. The law applies to health insurance issuers and providers licensed in State A and applies to the type of service provided. The Office of Personnel Management and the Federal Employee Health Benefits plan carrier, through the annual contract negotiation cycle, have elected to utilize State A's law, and the Federal Employee Health Benefits plan contains a term expressly incorporating the State A law prohibiting balance billing.

In Example 5, the Federal Employee Health Benefits plan contract terms apply the state law to prohibit balance billing and determine the cost-sharing amount and the out-of-network rate.

Example 6

Same facts as Example 5, except that the Federal Employee Health Benefits plan contract terms do not incorporate or expressly refer to the balance billing law of State A.



In Example 6, State A's law prohibiting balance billing would be preempted by the terms of the Federal Employee Health Benefits plan contract. Balance billing would be prohibited under the federal No Surprises Act and the lesser of the billed amount or QPA would apply to determine the cost-sharing amount. The out-of-network rate would be determined through open negotiation between the non-participating provider and the Federal Employee Health Benefits plans carrier, or in the case of failed negotiations, an amount determined under the federal Independent Dispute Resolution (IDR) process.



Questions and Answers on the No Surprises Act and State Laws



1. Do some states have their own laws to protect consumers from surprise medical bills?

Yes. Many states established their own protections against surprise medical billing before the No Surprises Act was enacted. As of February 5, 2021, 33 states had enacted legislation providing some protection for consumers from surprise bills.¹ The No Surprises Act created a new federal standard for surprise billing protections.

2. When are the No Surprises Act's surprise billing protections effective?

The No Surprises Act's rules generally apply to group health plans and group and individual health insurance coverage issuers with respect to plan or policy years beginning on or after January 1, 2022, as well as to health care providers and facilities, and providers of air ambulance services for items and services furnished during plan or policy years beginning on or after January 1, 2022. A plan or policy year generally is a 12-month period that is not necessarily the same as a calendar year. Some of the No Surprises Act protections have not been fully implemented and enforced. For more information see [No Surprises Act Protections: Status of Implementation](#).

3. Do the new rights under the No Surprises Act protect consumers in all states, the District of Columbia, and the U.S. Territories?

Yes. The new protections apply to the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

4. Does the No Surprises Act override existing state law consumer protections if a state has a surprise billing law?

No. The No Surprises Act supplements state surprise billing laws; it does not replace them. For example, if a state has a surprise billing law, but that law does not apply to a specific item or service, the No Surprises Act would apply (if otherwise applicable). If a state's surprise billing law provides at least the same level of consumer protections against surprise bills and against higher cost sharing as does the No Surprises Act and its regulations, the state law generally will apply.²

5. If a consumer receives a surprise bill for services in a state with its own surprise billing law, will the federal or state law apply?

It depends on factors such as whether the state surprise billing law applies to the specific item or service, type of health coverage the consumer has, and the non-participating provider or facility involved. If the state law applies to all, then generally the state law will apply as long as the law offers consumer protections equal to or stronger than the No Surprises Act.

¹ The Commonwealth Fund, State Balance billing Protections. https://www.commonwealthfund.org/sites/default/files/2021-03/Hoadley_state_balance_billing_protections_table_02052021.pdf.

² The term "state" in the No Surprises Act includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

6. Is cost sharing different if a consumer is protected under a state law?

It depends on the state. A state may have a “specified state law” that applies with respect to the consumer cost-sharing amount for the types of emergency services and certain non-emergency services (but not air ambulance services) covered by the No Surprises Act.

A “specified state law” is a state law that provides a method for determining the total amount payable to an out-of-network provider or facility. In cases where a specified state law applies, the out-of-network rate for items and services and the amount upon which consumer cost sharing is based are calculated according to the method provided in the specified state law.

7. What if a state has an All-Payer Model Agreement?

In states where an All-Payer Model Agreement (see [Glossary](#)) applies, certain cost sharing and payment rates will be based on the terms of the All-Payer Model Agreement rather than another methodology specified in the No Surprises Act. If a state has an All-Payer Model Agreement that determines payment amounts for out-of-network providers and facilities for a service, the All-Payer Model Agreement generally will determine the cost-sharing amount and the out-of-network payment rate for covered items and services.

8. How is enforcement different if a consumer is protected from surprising billing under a state law instead of the No Surprise Act?

Enforcement of state laws is handled by the respective state agencies, such as a state’s department of insurance. States have primary enforcement authority over health insurance issuers, facilities, and providers (including air ambulance services providers) with respect to the No Surprises Act. The Centers for Medicare & Medicaid Services (CMS) directly enforces any provision that a state fails to substantially enforce. If the applicable state authority lacks the authority but wants to participate in the enforcement of a provision, the applicable state authority may enter into an agreement with CMS regarding enforcement.

If a participant or beneficiary is covered by a self-insured group health plan (such as a health plan provided by an employer to its employees), a state will not be able to enforce its surprise billing protections unless the plan has opted into the state’s surprise billing law.

Call the No Surprises Help Desk at 1-800-985-3059 for assistance in determining whether federal law or a state law applies in a particular circumstance. The No Surprises Help Desk can also provide assistance in identifying relevant state enforcement agencies and other useful information.

9. Are some states changing their state laws?

Yes. Some states have indicated they are updating their laws to align more closely with the No Surprises Act.

10. What happens if a No Surprises Act-related complaint is submitted through the No Surprises Help Desk and a state law applies?

If a state law applies, the No Surprises Help Desk may direct consumers to the relevant state enforcement agency(ies).

5. Sample Documents

[GO BACK TO TOC](#)



Sample Notice and Consent Form

Form Used to Waive Surprise Billing Rights Under the No Surprises Act

Under certain circumstances, an out-of-network provider or facility is allowed to ask a consumer to waive their surprise billing protections under the No Surprises Act so the provider may balance bill the consumer.* In such circumstances, the consumer may agree to receive out-of-network services and pay more than their in-network cost sharing for rendered services.

For a consumer to waive surprise billing protections (for items and services that are eligible for waiver), the No Surprises Act allows the provider or facility to give the consumer a [notice and consent form](#) to ask the consumer to waive the protections. The notice and consent form must meet certain requirements, as reflected in the notice and consent form prepared by the federal government. Providers and facilities are required to use the federal notice and consent form unless a state develops a notice and consent form that meets the federal requirements.

To see when notice and consent to waive surprise billing protections is allowed, see [When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use](#). **Consumers are not required to waive their rights to protections under the No Surprises Act.** However, if they do not agree to waive their rights (where waiver is permitted), they may be required to reschedule care with an in-network provider.

See the [Decision Tree: Notice and Consent](#) for the notice and consent form requirements and information on how and when the form must be shared with the consumer. A provider may not balance bill or apply out-of-network cost-sharing to a consumer if the consent form does not meet the federal requirements, **even if the consumer signs it.**

Notice and consent is **NEVER** allowed when an out-of-network provider or facility is providing emergency services before a patient is stabilized. Additionally, the notice and consent exception is not applicable with respect to some non-emergency items or services, including ancillary services, and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.



Notice and Consent Must Be Completed Within Certain Timeframes:

- For an appointment scheduled at least 72 hours before the date that the items or services are to be furnished: the notice and consent documents must be provided at least 72 hours before the date of the appointment.
- For an appointment scheduled within 72 hours of the date the items or services are to be furnished: the notice and consent documents must be provided on the date the appointment is scheduled.
- If an individual receives the items and services on the same day that notice is provided: the notice and consent documents must be provided at least three hours prior to furnishing the relevant items or services.

* With respect to certain nonemergency services or certain post-stabilization services provided in the context of emergency care.

Sample Notice and Consent Form

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

1

Consumers are NOT required to sign the form. They do not have to waive their surprise billing protections.



Consumers can contact their health plan to find an in-network provider or ask for help with lowering the costs.

There are two versions of this form that could be used: a previous version that was only applicable in 2022, and a current version that can be used in 2022 and in later years. The example highlighted here is the 2022 and later form.

Sample Notice and Consent Form

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Estimate of what you could pay if you give up your protections

Patient name: _____

Out-of-network provider(s) or facility name: _____

Total cost estimate of what you may be asked to pay:	
---	--

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Contact [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]

► **Questions about your rights?** Contact [Insert contact information for appropriate federal or state agency. The federal phone number for information and complaints is: 1-800-985-3059]

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

More information about your rights and protections

Visit [Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers] for more information about your rights under federal law.

2

The total estimated costs show what the consumer may be charged if they waive their surprise billing protections. This must include all items or services that an out-of-network provider or facility providing nonemergency or post-stabilization services expects to charge.

Providers and facilities must provide contact information for someone to answer questions about the notice and estimate.

When this form is used to waive surprise billing protections for post-stabilization services (following emergency care) furnished by a nonparticipating provider at a participating emergency facility, a list of in-network providers must be provided. If no in-network providers offering post-stabilization items or services are available, or this section of the form is otherwise left blank, the consumer may not be balance billed or assessed out-of-network cost sharing.



Sample Notice and Consent Form

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from (select all that apply):

- [doctor's or provider's name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]
- [facility name]

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____ or _____	
Patient's signature	Guardian/authorized representative's signature
_____	_____
Print name of patient	Print name of guardian/authorized representative
_____	_____
Date and time of signature	Date and time of signature

**Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.**

3

All providers asking the consumer to waive their surprise billing protections must be listed here.



Again, consumers do not have to waive their protections. However, the out-of-network provider might not agree to treat them if they do not sign the form. If that happens, the provider cannot charge the consumer for cancelling the appointment.

Sample Notice and Consent Form

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

More details about your total cost estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.]

For each provider or facility described in the notice, fill-in the table below by completing each column for each item and service to be provided by the provider or facility. Add additional rows if necessary. If the notice is for more than one facility or provider, list items and services to be provided by the same facility or provider in adjacent rows, and provide a subtotal estimate for each facility and provider(s). If the notice is for one facility or one provider, the subtotal estimate may be omitted. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
Subtotal for [insert name of provider or facility]:				
Total estimate of what you may owe:				

Each provider or facility asking the consumer to waive surprise billing protections must be listed.

This total should match the total on page 2 of the notice and consent form.





Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Below is an example of a good faith estimate form for uninsured (or self-pay) individuals who are expected to receive a bill for their care. This sample form highlights key information that is required by the No Surprises Act. Providers and facilities do not have to use this specific form, as long as they use a form that includes the required information. For a full list of good faith estimate requirements, see the regulatory requirements at [45 CFR § 149.610\(c\)](#). To access the form, see the [Good Faith Estimate for Health Care Items and Services template](#).

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]		
Good Faith Estimate for Health Care Items and Services		
Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____ / _____ / _____		
Account Number (last four digits) (optional):		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: <input type="checkbox"/> By mail <input type="checkbox"/> By email <input type="checkbox"/> By phone		
Patient Diagnosis (if determined)		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided:		
<input type="checkbox"/> Check this box if this service or item is not yet scheduled		

The form must include information such as the patient's name, date of birth, and the primary item or service (with diagnosis codes).



Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

[Provider/Facility 3] Estimate [Delete if not needed]

Provider/Facility Name	Provider/Facility Type
------------------------	------------------------

[Provider/Facility 2] Estimate [Delete if not needed]

Provider/Facility Name	Provider/Facility Type
------------------------	------------------------

[Provider/Facility 1] Estimate

Provider/Facility Name	Provider/Facility Type
Street Address	
City	State ZIP Code
Contact	Person Phone Email
National Provider Identifier	Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 1] \$					
Additional Health Care Provider/Facility Notes					

The good faith estimate must include a list of items or services that are reasonably expected to be furnished for the period of care.

This list must be grouped by provider. The No Surprises Act requires the estimate to describe the items and services that will be provided by the convening provider as well as items and services that will be provided by any co-providers or co-facilities.

However, the federal government currently is not enforcing the requirement for co-providers and co-facilities, so individuals may still receive an estimate that does not contain information from co-providers or co-facilities.

Health Care Items/Services Expected to Be Separately Scheduled with Another Provider or Facility

DISCLAIMER: For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility [Instructions for obtaining a good faith estimate for the service/item, such as provider/facility name, address, phone number, and email]

Good faith estimates must include a list of items or services that will require separate scheduling. These items or services are expected to be provided before or after the period of care for the primary item or service. For example, physical therapy following knee surgery.



Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is \$400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a \$25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the \$25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

The good faith estimate must include a number of disclaimers. For example, it must state that the estimate is based on information known at the time it was created. Therefore, it won't include any costs for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events.

The good faith estimate must also explain that individuals have a right to initiate the Patient-Provider Dispute Resolution process if the billed charges from a provider or facility are \$400 or more than the estimate from that provider or facility.



Individuals should keep any estimate provided in a safe place to compare with any bills received later, in case they wish to dispute a bill through the Patient-Provider Dispute Resolution process. For more information, see background information on [what's a good faith estimate](#), [examples of good faith estimates that do and don't qualify for the dispute process](#) as well as the [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#) and the [Decision Tree: Patient-Provider Dispute Resolution Process](#).



Sample Good Faith Estimate Abbreviated Version

This form may only be used if the provider or facility preparing the estimate does not expect to bill the individual.



Below is an example of a good faith estimate form for uninsured (or self-pay) individuals who are expected to receive care at no cost. This is an abbreviated (shortened) version of a complete good faith estimate. Providers and facilities do not have to use this specific form as long as they use a form that includes the required information. For a full list of requirements for abbreviated good faith estimates, see [FAQS About Consolidated Appropriations Act, 2021 Implementation – Good Faith Estimates \(GFEs\) for Uninsured \(or Self-Pay\) Individuals – Part 4](#). To access the form, see [Abbreviated GFE for No Cost Health Care Items or Services](#).

Abbreviated Good Faith Estimate
Abbreviated GFE for No-Cost Health Care Items or Services

This abbreviated GFE should **only** be used by a provider or facility that **does not expect to bill the uninsured (or self-pay) individual** for items or services furnished on the date the items or services are expected to be provided.

[insert NAME OF PROVIDER OR FACILITY]

Good Faith Estimate for No-Cost Health Care Items & Services

This provider/facility will not bill you for items or services scheduled to be provided on [insert date(s)]
[If items or services have not been scheduled, replace with this: This provider/facility will not bill you for items or services.]

Patient Name:	Patient Date of Birth:	
Patient Identifier (optional):		
Provider/Facility Name:		
Provider/Facility Street Address (where items or services are expected to be furnished):		
City:	State:	ZIP Code:
Provider/Facility Contact:	Phone:	
Email Address:		
National Provider Identifier (NPI):	Taxpayer Identification Number (TIN):	
Date of Good Faith Estimate:		

Disclaimer

The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

There may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

The abbreviated good faith estimate must state that the provider or facility will not bill for items or services.

The form must include information such as:

- The individual's name and date of birth
- The provider's contact information
- The date of the good faith estimate
- The date of the appointment (for those who schedule an item or service at least 3 days in advance)

The abbreviated good faith estimate does not list expected items or services to be furnished from any provider or facility.

Sample Good Faith Estimate Abbreviated Version

If you do receive a bill that is \$400 or more, you may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. The initiation of this process will not adversely affect the quality of health care services furnished to an uninsured (or self-pay) individual by a provider or facility.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

For questions or more information about your right to a Good Faith Estimate, the dispute resolution process, or to get a form to start the dispute resolution process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed by the provider or facility.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

The form must include a number of disclaimers. For example, it must state that the individual may start the Patient-Provider Dispute Resolution process if they are billed \$400 or more.



Consumers should keep any estimate provided in a safe place to compare with any bills received later. Individuals who receive an abbreviated good faith estimate for items and services scheduled to be furnished may be able to initiate the Patient-Provider Dispute Resolution process if they receive a bill that is \$400 or more for items or services furnished on the expected date(s) of service listed on the abbreviated good faith estimate.

In some cases, an individual may request a good faith estimate without scheduling an item or service and they may receive an abbreviated good faith estimate with no date of service. If they later receive a bill for \$400 or more for any items or services, they may be able to start the Patient-Provider Dispute Resolution Process.

Please note there should always be a date on the abbreviated good faith estimate stating when it was provided. The abbreviated good faith estimate may also have an expected date of service.

For more information, see [Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#) and [Decision Tree: Patient-Provider Dispute Resolution Process](#).



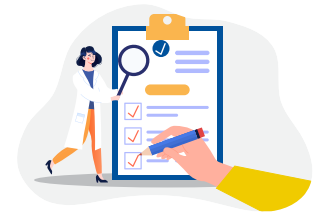
Sample Notice of Surprise Billing Protections

The No Surprises Act requires health care providers, facilities, health plans, health insurance issuers and Federal Employees Health Benefits (FEHB) Program carriers to notify consumers about their surprise billing protections. In general, providers and facilities that furnish items or services at a health care facility (such as hospitals and ambulatory surgical centers), or in connection with visits at health care facilities, must give this notice to individuals who have health plans or coverage subject to the No Surprises Act.

Providers and facilities shouldn't give these notices to an individual whose only coverage is Medicare, Medicaid, or any other form of coverage not subject to the No Surprises Act, or to an individual who is uninsured.

The notices must:

- Explain federal surprise billing restrictions;
- Identify and explain any applicable state law protections against surprise billing; and
- Identify how to contact the appropriate state and federal agencies in cases where protections may have been violated.



How the Notice Must Be Provided

Entity Providing Notice	Posted Publicly	Website	Other
Providers and facilities	Publicly available, such as where people schedule care, check-in for appointments, or pay bills. Not required if there is no publicly accessible location.	Must appear on a searchable public website of the provider or facility. Not required if the provider or facility does not have its own website.	<ul style="list-style-type: none"> • Must be provided in person, by mail, or email, as selected by the individual, to individuals who have health insurance coverage subject to the No Surprises Act. • Must be provided by the time payment is requested. • If no payment is requested, the notice must be provided by the time a claim is submitted to the consumer's health plan.
Health plans, issuers of group or individual health insurance coverage, FEHB carriers	Generally publicly available	Must be posted on a public website of the plan/issuer/FEHB carrier	Must be included on each explanation of benefits for items or services subject to the No Surprises Act

Sample Notice of Surprise Billing Protections

Federal Civil Rights Laws

For entities that receive federal financial assistance, the notice must comply with applicable federal civil rights laws that prohibit discrimination, which require covered entities to:

- Take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English; and
- Take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services.

For more information, see the [model disclosure notice instructions](#).

Below is an example of what the notice might look like. Providers, facilities, health plans, health insurance issuers, and FEHB carriers are not required to use this example, but the notice must comply with the requirements described in the [model disclosure notice instructions](#).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

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

[Summary of any applicable state billing laws or requirements or state-developed language]

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

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

The notice must explain surprise billing protections under the No Surprises Act. It must also explain any state laws that provide surprise billing protections.

continues on next page

Sample Notice of Surprise Billing Protections

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

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

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact *[Contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: 1-800-985-3059].*

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit [\[Link to state website\]](#) for more information about your rights under [\[Name of state\]](#) laws.
[If applicable, insert: Visit [\[website\]](#) for more information about your rights under [\[state laws\]](#).]

Consumers may be asked to sign a consent form waiving their surprise billing rights. They can refuse to sign the form.

Charges are limited to in-network cost-sharing when No Surprises Act protections apply.

The notice must tell the consumer where to turn for help if they believe they've been wrongly billed.

NOTE: The Department of Health and Human Services created two versions of the sample notice. The initial version, published under emergency approval from the Office of Management and Budget, was allowed for use in 2022 only. A revised, second version is for use in 2022 and beyond. The second version is pictured above.





Sample Notice of Uninsured (or Self-Pay) Individual's Right to Receive a Good Faith Estimate

Providers and facilities must post a **Notice of the Right to Receive a Good Faith Estimate for Uninsured (or Self-Pay) Individuals**.

Sample Notice

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

The notice must be clearly visible in the office and on-site where scheduling or questions about the cost of items or services occur, and be easy to find on the website of the provider or facility.

This document informs consumers about their new rights. No action is needed by consumers.

View this document: [Right to Receive a Good Faith Estimate of Expected Charges](#)

Providers generally must provide to consumers who are **uninsured** or choose not to use their insurance (**self-pay**) a **good faith estimate** if the consumer requests one or schedules care at least 3 business days before their visit.

The good faith estimate must be provided either on paper or electronically, such as through the provider's patient portal or e-mail, and in the format preferred by the consumer.

Consumers should keep the estimate to compare with any bills they later receive. They will need it if they wish to dispute the amount of the bill.

View a [Sample Good Faith Estimate for Uninsured \(or Self-Pay\) Individuals](#).

If a consumer is not expected to be billed, they may receive a shorter form. View a [Sample Good Faith Estimate Abbreviated Version](#). Note that providers and facilities are not required to use either exact form, as long as the form they use includes the required information.

If a consumer's bill is \$400 or more above the Good Faith Estimate for a provider or facility, the consumer may dispute the charges. View the [Decision Tree: Patient-Provider Dispute Resolution Process](#) to learn more about the Patient-Provider Dispute Resolution process. Visit this page to [start a dispute online](#).

6. Reference Materials

[GO BACK TO TOC](#)



No Surprises Act Consumer Advocate Toolkit

Glossary



Below are some common terms related to the No Surprises Act that are used throughout the Consumer Advocate Toolkit. For a complete list of terms commonly used in health insurance, please see the [HealthCare.gov Glossary](#).

- **Air Ambulance Service** – Medical transport by a helicopter or fixed-wing aircraft that is certified as an air ambulance. It also includes any medically necessary services and supplies provided by air ambulance staff during transportation.
- **All-Payer Model Agreement** – This is an Agreement between the Centers for Medicare & Medicaid Services and a state to test and operate new ways to structure the payment for the medical care of residents of the state. In an All-Payer Model Agreement, the rates for an item or service covered by the Agreement will generally be the same for all patients, regardless of the type of insurance they have. For example, the Maryland Total Cost of Care Model relies on the state’s all-payer hospital rate-setting system, wherein all health care payers (such as public and commercial insurers) pay the same rates for hospital services. All-Payer Model Agreements can vary significantly by state, including in using different approaches for setting payment amounts for items or services covered by the Agreements.
- **Allowed Amount** – This is the maximum payment the plan will pay for a covered health care service. It may also be called “eligible expense,” “payment allowance,” or “negotiated rate.” For example, if a consumer gets a service from an in-network provider who charges \$125 and their health plan’s allowed amount for that service is \$100, the consumer will pay \$100 for that service if they haven’t met their deductible. If the consumer has met their [deductible](#), they will pay their [coinsurance](#) or [copayment](#) amount instead, if applicable (see coinsurance, copayment, and deductible—defined below). The consumer will generally not be billed for the balance between the in-network provider charges of \$125 and the allowed amount of \$100.
- **Ancillary Services** – Under the No Surprises Act, ancillary services include the following: items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether 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 a nonparticipating provider if there is no participating provider who can furnish the item or service at that facility.

Providers and facilities may NEVER seek an individual’s consent to waive the No Surprises Act’s balance billing protections for non-emergency ancillary services through use of notice-and-consent exceptions.

- **Balance Billing** – When a provider bills a consumer for the balance remaining on the bill that the consumer’s plan doesn’t cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider’s charge is \$200 and the allowed amount is \$110, a bill for the remaining \$90 would be a “balance bill.” This happens most often when consumers see an out-of-network provider (non-preferred provider). An in-network provider (preferred provider) generally is not allowed to balance bill consumers for covered services. Note that sometimes a balance bill is considered a [surprise bill](#).

No Surprises Act Consumer Advocate Toolkit Glossary

- **Coinsurance** – A consumer’s share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. Consumers pay the coinsurance plus any deductibles they owe. For example, if a consumer’s health insurance plan’s allowed amount for an office visit is \$100 and the consumer’s coinsurance is 20%, the consumer will pay 20% of \$100, or \$20, if the consumer has met their deductible, and the insurance company will pay the rest. If the consumer has not paid their deductible yet, they will pay the full allowed amount, \$100 (or the remaining balance until they have paid the yearly deductible, whichever is less).
- **Complaint** – Under the No Surprises Act, a complaint is a communication (written or oral) that indicates there has been a potential violation of the No Surprises Act. If a consumer believes their provider, facility, provider of air ambulance services, or health plan didn’t follow the rules under the No Surprises Act, they can submit a complaint to the No Surprises Help Desk at 1-800-985-3059 or online using the [No Surprises Consumer Complaint Form](#). They may need to submit supporting documentation, such as medical bills and their Explanation of Benefits. For more information, see [No Surprises Act: How to Get Help and File a Complaint](#).
- **Copayment (or “Copoly”)** – A fixed amount a consumer pays for a covered health care service as the consumer’s share of the cost for an item or service, such as a doctor’s visit, hospital outpatient visit, or prescription drug. A copayment is a set amount, rather than a percentage. The amount can vary by the type of covered health care service. For example, if a consumer’s health plan’s allowable amount for a doctor’s office visit is \$100 and the copayment amount for a doctor’s office visit is \$20:
 - If the consumer has paid their deductible, they pay \$20, usually at the time of the visit.
 - If the consumer hasn’t met their deductible, they pay \$100, the full allowed amount for that visit (or the remaining balance until the consumer has paid their annual deductible, whichever is less).
- **Cost Sharing (or “Out of Pocket Costs”)** – The share of costs for covered services that consumers must pay out of pocket. Family cost sharing is the share of costs that a family (policy subscriber and dependents) must pay out of pocket. Cost sharing includes copayments, deductibles, and coinsurance. [Premiums](#), penalties, or the cost of care not covered by the plan are not considered cost sharing.
- **Deductible** – The amount a consumer must pay for covered health care services before their plan begins to pay. The deductible applies to a specific coverage period (usually one year). An overall deductible applies to all or almost all covered items and services. For example, if a consumer’s deductible is \$1,000, their plan won’t pay anything until the consumer has paid \$1,000 for covered health care services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles and no overall deductible.
- **Dispute** – For purposes of the patient-provider dispute resolution process under the No Surprises Act, a dispute is a disagreement about a medical bill by a consumer who doesn’t have insurance or doesn’t plan to use their insurance to pay for their care. If the medical bill is at least \$400 higher than an amount reflected on a [good faith estimate](#) for a specific provider, the consumer may be able to file a dispute through the patient-provider dispute resolution process. In this process, a consumer can ask an independent third party to review their case. The third party, called a Selected Dispute Resolution Entity, will review the good faith estimate, the consumer’s bill, and information from their health care provider or facility. The entity will then decide if the consumer should pay the amount on the consumer’s good faith estimate, the billed charge, or a different amount. During the patient-provider dispute resolution process, the consumer may continue to negotiate their bill with the provider or facility.

No Surprises Act Consumer Advocate Toolkit Glossary

For the purposes of the federal independent dispute resolution (IDR) process in the No Surprises Act, a dispute is a disagreement between an out-of-network provider, emergency facility, or provider of air ambulance services, and a group health plan, health insurance issuer, or Federal Employees Health Benefits carrier, where the parties disagree on the appropriate out-of-network payment under the plan or coverage for an item or service furnished by the provider or facility.

- **Emergency Department of a Hospital** – Hospital outpatient departments that provide emergency services.
- **Emergency Medical Condition** – A medical condition (including a mental health condition or substance use disorder) with symptoms of sufficient severity (including severe pain) that a prudent lay-person who has average knowledge of health and medicine could reasonably expect that failure to get immediate medical care may result in serious jeopardy to their health (or the health of their unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- **Emergency Services** – With respect to an emergency medical condition, an appropriate medical screening and any further medical examination and treatment that is required to stabilize a patient when furnished in relation to a visit to an emergency facility (and that is within the capabilities of the facility). For the purposes of the No Surprises Act, the definition of emergency services also includes [post-stabilization services](#). (The full regulatory definition of emergency services can be found at [45 CFR § 149.110\(c\)\(2\)](#)).
- **ERISA (Employee Retirement Income Security Act of 1974)** – A federal law that includes protections and rights for individuals who are covered by private, U.S.-based employment-based group health plans.
- **Explanation of Benefits (EOB)** – This is a summary from the consumer’s health plan of the total charges for the health care services the consumer received and how much the consumer and the health plan will have to pay. This could be a paper copy that’s mailed to the consumer or an electronic statement. This is not a bill.
- **Fully-Insured Employer Plan** – A fully-insured employer plan is a health plan purchased by an employer from an insurance company. The insurance company, instead of the employer, takes on the responsibility of paying employees’ and dependents’ medical claims in exchange for a premium from the employer.
- **Good Faith Estimate (GFE) for Uninsured (or Self-Pay) Individual** – An estimate from a health care provider or facility of expected costs for items or services for uninsured (or self-pay) individuals. The provider or facility generally must give the consumer a good faith estimate before they get a health care service if they ask for one or if they schedule a service at least 3 days before they get a health care service.
- **Health Coverage** – Legal entitlement to payment or reimbursement for health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP).
- **In-Network Providers (also called “Participating Providers” or “Preferred Providers”)** – Providers or facilities that have a contract with a consumer’s health plan to provide services for plan members at certain costs. Generally, if a consumer gets care with an in-network provider or facility, it will cost the consumer less than if the consumer gets care with an out-of-network provider or facility.
- **Independent Freestanding Emergency Facility** – Health care facilities that are geographically separate and distinct and licensed separately from a hospital under applicable state law and provide any emergency services. Urgent care centers can be treated as independent, freestanding emergency departments if they meet this definition of an independent, freestanding emergency department.

No Surprises Act Consumer Advocate Toolkit Glossary

- **Insured Individual** – Someone with health coverage (this can include people with coverage through their employer; a Health Insurance Marketplace^{®,1}; an insurance company, purchased directly or through an insurance agent or broker; Medicare; Medicaid; or TRICARE).
- **No Surprises Act** – A federal law that provides protections against getting surprise medical bills for out-of-network emergency services, some out-of-network non-emergency services related to a patient visit to an in-network facility, and out-of-network air ambulance services. Visit [CMS.gov/nosurprises](https://www.cms.gov/nosurprises) for more information.
- **Notice and Consent Form (or Waiver)** – A form that gives consumers the option to waive their protections against surprise medical bills in certain circumstances. If a consumer signs this form, they agree to give up rights that protect them from balance billing and they may be charged more for their medical care. The form must also include a good faith estimate of what the consumer may be charged if they give up their rights. This type of notice and consent form is separate from other medical consent forms that a provider or facility may ask consumers to sign before treating them. See the [Standard Notice and Consent Form](#). For more information, see [When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use](#).
- **Out-of-Network Provider (also called “non-preferred” or “nonparticipating” provider)** – A provider who doesn't have a contract with a consumer's health plan to provide services. A consumer will usually pay more to see an out-of-network provider than an in-network provider. The consumer's policy will explain what those costs may be.
- **Out-of-Pocket Limit** – The most a consumer could pay during a coverage period (usually one year) for their share of the costs of covered services. After the consumer meets this limit, the plan will usually pay 100% of the allowed amount. This limit never includes the premiums, balance-billed charges, or care that the consumer's plan doesn't cover. Some plans don't count all of a consumer's copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.
- **Post-Stabilization Services** – For the purposes of the No Surprises Act, post-stabilization services are services provided by an out-of-network provider or emergency facility after a consumer's emergency medical condition is stabilized. These services must be provided as part of outpatient observation, an outpatient stay, or an inpatient stay. Post-stabilization services are considered to be [emergency services](#) under the No Surprises Act unless certain conditions are met, in which case the provisions related to notice and consent to waive balance billing may apply.
- **Premium** – The amount the consumer pays for their health insurance every month. In addition to their premium, the consumer usually has to pay other costs for their health care, including a deductible, copayments, and coinsurance. If a consumer has a Marketplace health plan, they may be able to lower their costs with a premium tax credit.
- **Provider** – An individual or facility that provides health care services. Examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. A health plan may require the provider to be licensed, certified, or accredited as required by state law.
- **Qualifying Payment Amount (QPA)** – An amount that is generally based on a median contracted rate for an item or service that a health plan pays to providers who are in the same or similar specialty within a geographic area.



¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

No Surprises Act Consumer Advocate Toolkit Glossary

- **Recognized Amount** – A dollar amount that serves as a basis for calculating a consumer’s cost sharing under the No Surprises Act for certain items and services.
 - In states with All-Payer Model Agreements, the recognized amount is the amount that the state approves under the All-Payer Model Agreement for an item or service.
 - In states with specified state laws (and no All-Payer Model Agreement), the recognized amount is the amount determined by the state law.
 - In states without an All-Payer Model Agreement or applicable state law, the recognized amount is either the amount billed by a provider or facility for an item or service or the [Qualifying Payment Amount](#), whichever is lower.
- **Self-Insured Employer Health Plan** – A self-insured (or self-funded) employer plan is a form of health care coverage offered by employers to their employees. This is a type of health plan that is usually offered by larger companies where the employer itself takes on the responsibility of paying employees’ and dependents’ medical claims. These employers can contract with a third-party administrator for services such as enrollment, claims processing, and managing provider networks, or they can self-administer these services. Self-insured plans are regulated by the federal government and generally are not subject to state insurance laws.
- **Self-Pay** – When a consumer has health coverage but is not seeking to have claims submitted to their plan or insurance for items or services, and instead plans to pay for the items or services out of pocket.
- **Surprise Bill (also called a Surprise Medical Bill)** – An unexpected [balance bill](#) for certain types of out-of-network costs that a consumer’s health insurance didn’t cover.
- **Uninsured** – For purposes of the No Surprises Act, uninsured means a consumer who is not covered under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a Federal Employees Health Benefits plan, or Federal health care program.



No Surprises Act Consumer Advocate Toolkit: Legal Citations

This resource provides the legal citations in the United States Code as well as the Code of Federal Regulations for consumer protections in key sections of the federal statutes known as the No Surprises Act. The United States Code contains the provisions of the No Surprises Act, which amended the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (IRC), and the Federal Employees Health Benefits (FEHB) Act. The No Surprises Act gives the Departments of Health and Human Services (HHS), Labor (DOL), the Treasury (collectively, “the Departments”) and the Office of Personnel Management (OPM) the authority to implement the statutes. The Code of Federal Regulations, also known as the CFR, contains regulations issued by the Departments and OPM to implement the No Surprises Act. The tables below list some of the key consumer protection provisions under the No Surprises Act and the associated legal authority as it pertains to health plans, issuers, FEHB carriers, providers, providers of air ambulance services, and health care facilities regulated by each of the implementing Departments and OPM.

Note: Some provisions of the regulations have been vacated by *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-372-JDK (TMA II); *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-450-JDK (TMA III); or *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:23-cv-00059-JDK (TMA IV). These decisions vacated portions of the rules or guidance related to independent dispute resolution (IDR) considerations for reaching a payment determination, batching of IDR disputes, the administrative fee amount for IDR disputes, requirements related to the timeframe for sending an initial payment or notice of denial of payment, the methodology for calculating qualifying payment amounts (QPAs), and provisions pertaining to air ambulance disputes. Please review the opinions in the cases cited above for further information on which provisions of the regulations or guidance were vacated and the notes on our [website](#) about applicable guidance.

Contents

- SURPRISE BILLING 3**
- Sec. 102. Health insurance requirements regarding surprise medical billing 3
 - Coverage of emergency services 3
 - Coverage of non-emergency services. 3
- DETERMINATION OF OUT-OF-NETWORK RATES; HEALTH CARE PROVIDER REQUIREMENTS 3**
- Sec. 103. Determination of out-of-network rates to be paid by health plans; independent dispute resolution process (IDR). 3
- Sec. 104. Health care provider requirements regarding surprise medical billing. 3
 - Emergency services 3
 - Non-emergency services 3
 - Provider disclosure 3
 - Enforcement 3
- ENDING SURPRISE AIR AMBULANCE BILLS; REPORTING REQUIREMENTS 4**
- Sec. 105. Ending surprise air ambulance bills 4
 - Out-of-network air ambulance services, IDR process 4
- Sec. 106. Reporting requirements regarding air ambulance services. 4
- TRANSPARENCY; KEY CONSUMER PROTECTIONS 4**
- Sec. 107. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations. 4
- Sec. 110. Consumer protections through application of health plan external review in cases of certain surprise medical bills. 4
- Sec. 111. Consumer protections through health plan requirement for fair and honest advance cost estimate. 4

No Surprises Act Consumer Advocate Toolkit: Legal Citations

Sec. 112. Patient protections through transparency and patient-provider dispute resolution	4
Good faith estimate	4
Patient-provider dispute resolution	5
Sec. 113. Ensuring continuity of care	5
Sec. 114. Maintenance of price comparison tool	5
Sec. 116. Protecting patients and improving the accuracy of provider directory information	5
Public disclosure of individual protections against balance billing.	5

No Surprises Act Consumer Advocate Toolkit: Legal Citations

SURPRISE BILLING

No Surprises Act Sections and Titles	HHS	HHS	DOL	DOL	Treasury	Treasury	OPM
	PHSA ¹ (U.S. Code [U.S.C.])	Code of Federal Regulations (CFR)	ERISA ² (U.S.C.)	CFR	Internal Revenue Code (IRC) (U.S.C.)	CFR	FEHB Act ³ (U.S.C.); (CFR)
Sec. 102. Health insurance requirements regarding surprise medical billing	PHSA Sec. 2799A-1(a) and (b) (42 U.S.C. § 300gg-111)	45 CFR §§ 149.10 through 149.150	ERISA Sec. 716 (29 U.S.C. § 1185e)	29 CFR §§ 2590.716-1 through 2590.716-7; 29 CFR § 2590.717-1	IRC Sec. 9816 (26 U.S.C. § 9816)	26 CFR §§ 54.9816-1T through 54.9816-6T, 54.9817-1T, 54.9817-2, 54.9817-2T	5 U.S.C. § 8902(p); 5 CFR § 890.114
• Coverage of emergency services	PHSA Sec. 2799A-1(a) (42 U.S.C. § 300gg-111(a))	45 CFR § 149.110	ERISA Sec. 716(a) (29 U.S.C. § 1185e(a))	29 CFR § 2590.716-4	IRC Sec. 9816(a) (26 U.S.C. § 9816(a))	26 CFR § 54.9816-4T	5 U.S.C. § 8902(p); 5 CFR § 890.114
• Coverage of non-emergency services	PHSA Sec. 2799A-1(b) (42 U.S.C. § 300gg-111(b))	45 CFR § 149.120	ERISA Sec. 716(b) (29 U.S.C. § 1185e(b))	29 CFR § 2590.716-5	IRC Sec. 9816(b) (26 U.S.C. § 9816(b))	26 CFR § 54.9816-5T	5 U.S.C. § 8902(p); 5 CFR § 890.114

DETERMINATION OF OUT-OF-NETWORK RATES; HEALTH CARE PROVIDER REQUIREMENTS

No Surprises Act Sections and Titles	HHS	HHS	DOL	DOL	Treasury	Treasury	OPM
	PHSA (U.S. Code [U.S.C.])	Code of Federal Regulations (CFR)	ERISA (U.S.C.)	CFR	Internal Revenue Code (IRC) (U.S.C.)	CFR	FEHB Act (U.S.C.); (CFR)
Sec. 103. Determination of out-of-network rates to be paid by health plans; IDR process	PHSA Sec. 2799A-1(c) (42 U.S.C. § 300gg-111(c))	45 CFR § 149.510	ERISA Sec. 716(c) (29 U.S.C. § 1185e(c))	29 CFR § 2590.716-8	IRC Sec. 9816(c) (26 U.S.C. § 9816(c))	26 CFR § 54.9816-8T; 26 CFR § 54.9816-8	5 U.S.C. § 8902(p); 5 CFR § 890.114
Sec. 104. Health care provider requirements regarding surprise medical billing	PHSA Sec. 2799B-1 through Sec. 2799B-4 (42 U.S.C. Chapter 6A, Subchapter XXV, Part E)	45 CFR §§ 149.410–149.450 (Subpart E)	*	*	*	*	*
• Emergency services	PHSA Sec. 2799B-1 (42 U.S.C. § 300gg-131)	45 CFR § 149.410	*	*	*	*	*
• Non-emergency services	PHSA Sec. 2799B-2 (42 U.S.C. § 300gg-132)	45 CFR § 149.420	*	*	*	*	*
• Provider disclosure	PHSA Sec. 2799B-3 (42 U.S.C. § 300gg-133)	45 CFR § 149.430	*	*	*	*	*
• Enforcement	Sec. 2799B-4 (42 U.S.C. § 300gg-134)	Proposed 45 CFR § 150; 45 CFR § 149.450	ERISA Sec. 522 (29 U.S.C. § 1152)	*	*	*	*

Table notes:

- 1) The hyperlinks in these tables may take readers to the main section of a statute or regulation. Readers may need to scroll through the hyperlinked pages to locate the statutory or regulatory section cited.
- 2) Electronic updates to the U.S. Code occur regularly. For the most recent U.S. Code, please see: [United States Code | GovInfo](#).
- 3) An asterisk generally indicates there are no corresponding No Surprises Act statutes or regulations at this time. For example, there may be no corresponding statutory provision, or regulations may not have been issued yet. Please note in some cases, there might be other relevant authorities.

No Surprises Act Consumer Advocate Toolkit: Legal Citations

ENDING SURPRISE AIR AMBULANCE BILLS; REPORTING REQUIREMENTS

No Surprises Act Sections and Titles	HHS	HHS	DOL	DOL	Treasury	Treasury	OPM
	PHSA (U.S. Code [U.S.C.])	Code of Federal Regulations (CFR)	ERISA (U.S.C.)	CFR	Internal Revenue Code (IRC) (U.S.C.)	CFR	FEHB Act (U.S.C.); (CFR)
Sec. 105. Ending surprise air ambulance bills	PHSA Sec. 2799A-2 (42 U.S.C. § 300gg-112(a))	45 CFR § 149.130	ERISA Sec. 717 (29 U.S.C. § 1185f)	29 CFR § 2590.717-1	IRC Sec. 9817 (26 U.S.C. § 9817(a))	26 CFR § 54.9817-1T	5 U.S.C. § 8902(p) ; 5 CFR § 890.114
• Out-of-network air ambulance services, IDR process	PHSA Sec. 2799A-2(b) (42 U.S.C. § 300gg-112(b))	45 CFR § 149.440 ; 45 CFR § 149.520	ERISA Sec. 717 (29 U.S.C. § 1185f(b))	29 CFR § 2590.717-2	IRC Sec. 9817 (26 U.S.C. § 9817(b))	26 CFR § 54.9817-2T ; 26 CFR § 54.9817-2	5 U.S.C. § 8902(p) ; 5 CFR § 890.114
Sec. 106. Reporting requirements regarding air ambulance services	PHSA Sec. 2799A-8 ⁴ (42 U.S.C. § 300gg-118)	Proposed 45 CFR 149.230 and 149.460	ERISA Sec. 723 (29 U.S.C. § 1185l)	Proposed 29 CFR 2590.723	IRC Sec. 9823 (26 U.S.C. § 9823)	Proposed 26 CFR 54.9823-1	*

TRANSPARENCY; KEY CONSUMER PROTECTIONS

No Surprises Act Sections and Titles	HHS	HHS	DOL	DOL	Treasury	Treasury	OPM
	PHSA (U.S. Code [U.S.C.])	Code of Federal Regulations (CFR)	ERISA (U.S.C.)	CFR	Internal Revenue Code (IRC) (U.S.C.)	CFR	FEHB Act (U.S.C.); (CFR)
Sec. 107. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations	PHSA Sec. 2799A-1(e) (42 U.S.C. § 300gg-111(e))	*	ERISA Sec. 716(e) (29 U.S.C. § 1185e(e))	*	IRC Sec. 9816 (26 U.S.C. § 9816(e))	*	5 U.S.C. § 8902(p) ; 5 CFR § 890.114
Sec. 110. Consumer protections through application of health plan external review in cases of certain surprise medical bills	The law expands the scope of the external review requirements [PHSA Sec. 2719(b) (42 U.S.C. § 300gg-19(b))] to include consideration of whether a plan or issuer is in compliance with the PHSA 2799A-1 and 2799A-2 (42 U.S.C. § 300gg-111 and 42 U.S.C. § 300gg-112)	45 CFR § 147.136(a)(1)(ii) ; 45 CFR § 147.136(c)(2)(i) ; 45 CFR § 147.136(d)(1)(i)(B)	The law expands the scope of the external review requirements to include consideration of whether a plan or issuer is in compliance with ERISA Secs. 716 and 717 (29 U.S.C. § 1185e , 29 U.S.C. § 1185f)	29 CFR § 2590.715-2719(a)(1)(ii) ; 29 CFR § 2590.715-2719(c)(2)(i) ; 29 CFR § 2590.715-2719(d)(1)(i)(B)	The law expands the scope of the external review requirements to include consideration of whether a plan or issuer is in compliance with IRC Sec. 9816, 9817 (26 U.S.C. § 9816 , 26 U.S.C. § 9817)	26 CFR § 54.9815-2719T(a)(1)(ii) ; 26 CFR § 54.9815-2719T(c)(2)(i) ; 26 CFR § 54.9815-2719T(d)(1)(i)(B)	OPM's Federal Employees Health Benefits (FEHB) Program has an existing disputed claims process at 5 CFR 890.105
Sec. 111. Consumer protections through health plan requirement for fair and honest advance cost estimate	PHSA Sec. 2799A-1(f) (42 U.S.C. § 300gg-111(f))	*	ERISA Sec. 716(f) (29 U.S.C. § 1185e(f))	*	IRC Sec. 9816(f) (26 U.S.C. § 9816(f))	*	5 U.S.C. § 8902(p)
Sec. 112. Patient protections through transparency and patient-provider dispute resolution	PHSA Sec. 2799B-6 (42 U.S.C. § 300gg-136)	45 CFR § 149.610 and 45 CFR § 149.620	*	*	*	*	*
• Good faith estimate	PHSA Sec. 2799B-6 (42 U.S.C. § 300gg-136)	45 CFR § 149.610	*	*	*	*	*

No Surprises Act Consumer Advocate Toolkit: Legal Citations

TRANSPARENCY; KEY CONSUMER PROTECTIONS (CONTINUED)

No Surprises Act Sections and Titles	HHS	HHS	DOL	DOL	Treasury	Treasury	OPM
	PHSA (U.S. Code [U.S.C.])	Code of Federal Regulations (CFR)	ERISA (U.S.C.)	CFR	Internal Revenue Code (IRC) (U.S.C.)	CFR	FEHB Act (U.S.C.); (CFR)
• Patient-provider dispute resolution	PHSA Sec. 2799B-7 (42 U.S.C. § 300gg-137)	45 CFR § 149.620	*	*	*	*	*
Sec. 113. Ensuring continuity of care	PHSA Sec. 2799A-3 (42 U.S.C. § 300gg-113); PHSA Sec. 2799B-8 (42 U.S.C. § 300gg-138)	*	ERISA Sec. 718 (29 U.S.C. § 1185g)	*	IRC Sec. 9818 (26 U.S.C. § 9818)	*	See FEHB Carrier Letter 2022-12
Sec. 114. Maintenance of price comparison tool	PHSA Sec. 2799A-4 (42 U.S.C. § 300gg-114)	*	ERISA Sec. 719 (29 U.S.C. § 1185h)	*	IRC Sec. 9819 (26 U.S.C. § 9819)	*	*
Sec. 116. Protecting patients and improving the accuracy of provider directory information	PHSA Sec. 2799A-5 (42 U.S.C. § 300gg-115 , 42 U.S.C. § 300gg-139)	*	ERISA Sec. 720 (29 U.S.C. § 1185i)	*	IRC Sec. 9820 (26 U.S.C. § 9820)	*	See FEHB Carrier Letter 2022-12
• Public disclosure of individual protections against balance billing	PHSA Sec. 2799A-5(c) (42 U.S.C. § 300gg-115(c))	*	ERISA Sec. 720(c) (29 U.S.C. § 1185i(c))	*	IRS Sec. 9820(c) (26 U.S.C. § 9820(c))	*	*

Endnotes

¹ PHSA is the Public Health Service Act.

² ERISA is the Employee Retirement Income Security Act of 1974.

³ The FEHB Act is the Federal Employees Health Benefits (FEHB) Act.

⁴ Section 106(a) of the No Surprises Act is codified in the United States Code as a note to PHS Act section 2799A-8. (86 FR 51733). As such, the enforcement provisions under PHS Act section 2723 and 45 CFR part 150 extend to PHS Act section 2799A-8, air ambulance data reporting requirements, on issuers and non-Federal governmental group health plans.

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<https://www.cms.gov/nosurprises/>

