

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

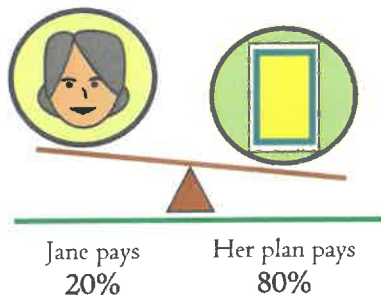
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

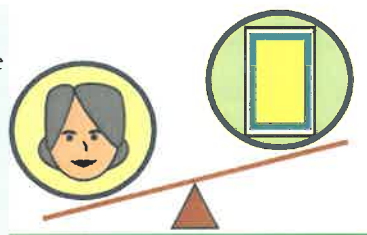
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and 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. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the [premium tax credit](#).

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

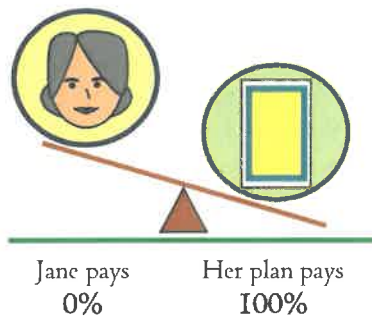
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for

health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "[health insurance](#)."

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called "prior authorization," "prior approval," or "precertification." Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each "tier" of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is *not* the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

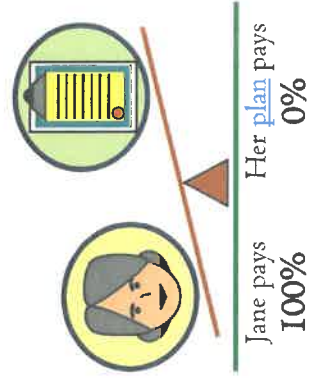
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

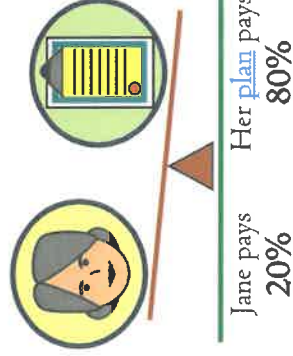
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



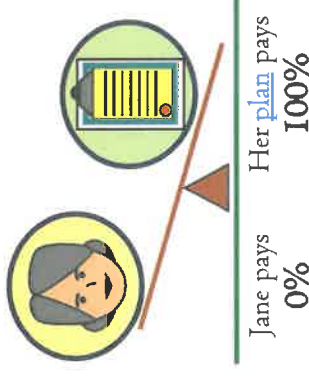
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0



Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: \$125
Jane pays: 20% of \$125 = \$25
Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: \$125
Jane pays: \$0
Her plan pays: \$125

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Consolidated Appropriations Act Disclosure for Plan Members

The Consolidated Appropriations Act (CAA) is a comprehensive set of laws that include the No Surprises Act (NSA) and transparency provisions. Plan Sponsors are required to post an NSA Notice in a prominent location in the workplace and/or post a link to the NSA Notice on the searchable home page of their websites. The Department of Labor (DOL) has provided a model notice, which should be used for plan years beginning on or after January 1, 2022.

Your Rights and Protections Against Surprise Medical Bills

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

If you get other 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

**NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**
[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- *Health Plans* must also:
 - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
 - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
 - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- *Covered Direct Treatment Providers* must also:

- ▶ Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
 - ▶ When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
 - ▶ In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
 - ▶ Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

[FAQs on Notice of Privacy Practices](#)

[FAQs on ALL Privacy Rule Topics](#)

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Bernie Lipman, Associate Director Benefits.

Fact Sheet



U.S. Department of Labor
Employee Benefits Security Administration

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication [Your Rights After A Mastectomy](#).

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication [Compliance Assistance Guide - Health Benefits Coverage Under Federal Law](#).

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

<p align="center">GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p align="center">INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p align="center">UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>
<p align="center">WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p align="center">WEST VIRGINIA – Medicaid and CHIP</p> <p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

FAQ ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 67

May 1, 2024

Set out below is a Frequently Asked Question (FAQ) regarding implementation of certain provisions of Title I (the No Surprises Act)¹ of Division BB of the Consolidated Appropriations Act, 2021, in light of the August 24, 2023, decision in *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-450-JDK (E.D. Tex.) (*TMA III*). This FAQ has been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM). Like previously issued FAQs (available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs> and <http://www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html>), this FAQ answers a question from stakeholders to help people understand the law and promote compliance.

The No Surprises Act

Sections 102 and 103 of the No Surprises Act added section 9816 to the Internal Revenue Code (Code), section 716 to the Employee Retirement Income Security Act (ERISA), and section 2799A-1 to the Public Health Service Act (PHS Act). Section 104 of the No Surprises Act added sections 2799B-1 and 2799B-2 to the PHS Act. Section 105 of the No Surprises Act added section 9817 to the Code, section 717 to ERISA, and sections 2799A-2 and 2799B-5 to the PHS Act. These provisions provide protections against surprise medical bills for participants, beneficiaries, and enrollees in a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to out-of-network services subject to the No Surprises Act.²

In July 2021, the Departments and OPM issued interim final rules implementing several of these statutory provisions (July 2021 interim final rules).³ The Departments have also previously issued guidance on various No Surprises Act implementation issues, including FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55.⁴

The No Surprises Act and the July 2021 interim final rules generally prohibit balance billing and limit cost sharing for emergency services provided by nonparticipating providers and nonparticipating emergency facilities, non-emergency services provided by nonparticipating

¹ Pub. L. 116-260, 134 Stat. 1182 (2020).

² No Surprises Act section 102(d)(1) added 5 U.S.C. 8902(p) to require that Federal Employees Health Benefits Program (FEHB) carriers provide these protections to their enrollees. OPM regulations are set forth at 5 CFR 890.114. For purposes of this document, the term “plans and issuers” includes FEHB carriers to the extent consistent with 5 CFR 890.114.

³ 86 FR 36872 (July 13, 2021). The Departments published final rules on August 26, 2022, that finalized certain provisions of the July 2021 interim final rules. 87 FR 52618 (Aug. 26, 2022).

⁴ FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (Aug. 19, 2022), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf> and <https://www.cms.gov/files/document/faqs-part-55.pdf>.

providers with respect to a visit to a participating health care facility,⁵ and air ambulance services provided by nonparticipating providers of air ambulance services. However, if patients are provided notice and give consent to waive surprise billing protections, consistent with applicable requirements, nonparticipating providers and nonparticipating emergency facilities may balance bill for certain post-stabilization services and for certain non-emergency services furnished with respect to a visit to a participating health care facility, in limited circumstances.⁶

Patient Cost Sharing

Under the No Surprises Act and the July 2021 interim final rules, cost-sharing requirements for out-of-network emergency services and applicable non-emergency items and services cannot be greater than the requirements that would apply if the services were provided by a participating provider or participating emergency facility and must be calculated based on the “recognized amount,” which is:

- (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified State law; or
- (3) if there is no such applicable All-Payer Model Agreement or specified State law, the lesser of the billed charge or the qualifying payment amount (QPA).⁷

Cost-sharing requirements for out-of-network air ambulance services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services and must be calculated using the lesser of the billed charge or the QPA.

The QPA is generally the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished, increased for inflation. Under the July 2021 interim final rules, the median contracted rate was determined with respect to all plans of the plan sponsor (or, if applicable, administering entity) or all coverage offered by the issuer that are offered in the same insurance market. The Departments established the methodology for

⁵ A health care facility, in the context of non-emergency services, is defined as (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. Code section 9816(b)(2)(A)(ii), ERISA section 716(b)(2)(A)(ii), and PHS Act section 2799A-1(b)(2)(A)(ii); 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

⁶ 26 CFR 54.9816-4T(c)(2)(ii)(B) and 54.9816-5T(b); 29 CFR 2590.716-4(c)(2)(ii)(B) and 2590.716-5(b); and 45 CFR 149.110(c)(2)(ii)(B) and 149.120(b); 86 FR 36872, 36906 (July 13, 2021) (providing that individuals are allowed to waive their balance billing protections “only after receiving a written notice that includes detailed information designed to ensure that individuals knowingly accept out-of-pocket charges (including charges associated with balance bills) for care received from a nonparticipating provider or nonparticipating emergency facility”).

⁷ The term “recognized amount” is defined at 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

calculating the QPA in the July 2021 interim final rules, including the methodology to apply when a plan or issuer lacks sufficient information to calculate a median contracted rate.⁸

The District Court's Decision in *TMA III*

On August 24, 2023, the United States District Court for the Eastern District of Texas (district court) issued an opinion and order in *TMA III* vacating certain provisions of the July 2021 interim final rules as well as certain portions of several No Surprises Act guidance documents issued by the Departments.⁹ The district court in *TMA III* held that several provisions of the regulations and guidance are unlawful and vacated and remanded them for further consideration, including provisions related to the methodology for calculating the QPA. The Department of Justice partially appealed the district court's decision in *TMA III*, which remains pending before the United States Court of Appeals for the Fifth Circuit.

FAQs Part 62

On October 6, 2023, the Departments and OPM issued FAQs About Consolidated Appropriations Act, 2021 Implementation Part 62 (FAQs Part 62).¹⁰ In FAQs Part 62, the Departments and OPM acknowledged the impact of the *TMA III* decision on QPAs and the significant resources and challenges associated with recalculating QPAs. Therefore, the FAQs stated that the Departments and OPM would exercise their enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer, or party to a payment dispute in the Federal IDR process, that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III*, for items and services furnished before May 1, 2024, the first day of the calendar month that is 6 months after the issuance of FAQs Part 62.¹¹ Under FAQs Part 62, this exercise of enforcement discretion applies to QPAs for purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and providing required disclosures and submissions under the Federal IDR process.

FAQs Part 62 stated that HHS would also exercise enforcement discretion under the relevant No Surprises Act provisions for a provider, facility, or provider of air ambulance services that bills, or holds liable, a participant, beneficiary, or enrollee for a cost-sharing amount based on a QPA calculated using the aforementioned method.

The FAQs further stated that, if necessary, the Departments and OPM would reevaluate in a timely fashion whether additional time for the enforcement relief was necessary as plans and issuers took reasonable steps to come into compliance with the applicable statutes and regulations that remain in effect after the *TMA III* decision. The FAQs stated that the Departments and OPM did not expect any such additional time would extend beyond November

⁸ 26 CFR 54.9816-6T, 29 CFR 2590.716-6, and 45 CFR 149.140.

⁹ See *Texas Med. Ass'n et al. v. U.S. Dep't of Health and Human Servs. et al.*, No. 6:22-cv-450-JDK (E.D. Tex. Oct. 20, 2023), and *Texas Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 23-40605.

¹⁰ FAQs about Consolidated Appropriations Act, 2021 Implementation Part 62 (Oct. 6, 2023), available at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-62.pdf> and <https://www.cms.gov/files/document/faqs-part-62.pdf>.

¹¹ FAQs Part 62, Q1.

1, 2024, the first day of the calendar month that is 12 months after the issuance of FAQs Part 62, but the Departments and OPM would reassess the status of QPA calculations and provide additional guidance as appropriate.

Q: Will the enforcement relief regarding the use of QPAs announced by the Departments and OPM in FAQs Part 62 be extended?

Yes. Since the issuance of FAQs Part 62, the Departments and OPM have received feedback that, despite taking reasonable steps to come into compliance, plans and issuers need additional time to complete the significant efforts associated with recalculating QPAs in a manner consistent with the statutes and regulations that remain in effect after the *TMA III* vacatur, as several of the changes to the QPA calculation methodology necessitate a manual process to locate data. Therefore, the Departments and OPM consider it appropriate to extend the enforcement relief provided in FAQs Part 62. Accordingly, the Departments and OPM will exercise their enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer, or party to a payment dispute in the Federal IDR process, that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III*, for items and services furnished before November 1, 2024.

Similarly, for items and services furnished before November 1, 2024, HHS will exercise enforcement discretion under the relevant No Surprises Act provisions for a provider, facility, or provider of air ambulance services that bills, or holds liable, a participant, beneficiary, or enrollee for a cost-sharing amount based on a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III*.

HHS encourages States that are the primary enforcers of the relevant No Surprises Act provisions with respect to issuers, providers, facilities, or providers of air ambulance services to adopt a similar approach to enforcement. HHS will not consider a State to be failing to substantially enforce these provisions because the State adopts such an approach.

The Departments and OPM will continue to assess the status of QPA calculations but do not expect to further extend this enforcement relief for items and services furnished on or after November 1, 2024.