Crosswalk of Changes

Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in

(CMS-10780/OMB control number: 0938-1401)

The following changes were made to the Standard Notice and Consent Documents Under the No Surprises Act:

Section Edited	Revision (Red indicates modified Language)
Instructions, page 1	Added: Providers and facilities should NOT give these documents to an individual: • Who is seeking items or services from in-network providers only, • Who has Medicare, Medicaid, or any form of coverage other than as previously described, or • Who is uninsured.
Instructions, page 1	These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420 with respect to both form and manner of delivery, the state-developed documents will meet the ~~Secretary's~~ federal specifications regarding the form and manner of the notice and consent documents.
Instructions, page 1	In particular, providers and facilities must fill in the blanks in the "Estimate of what you ~~may~~ could pay" section and the "More details about your total cost estimate" section before presenting the documents to patients.
Instructions, page 2	The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements. The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual

	or authorized representative. The individual or authorized representative must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual or authorized representative.
Instructions, page 2	Rewritten in all capitals: ~~Do not include these instructions with the standard notice and consent documents given to patients.~~ DO NOT INCLUDE THESE INSTRUCTIONS WITH THE STANDARD NOTICE AND CONSENT DOCUMENTS GIVEN TO PATIENTS.
Surprise Billing Protection Form, page 1	~~The purpose of this document is to let you know about~~ This document describes your protections ~~from~~ against unexpected medical bills. It also asks ~~whether~~ if ~~you would~~ you'd like to give up those protections and pay more for out-of-network care.
Surprise Billing Protection Form, page 1 (box)	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 ~~when you received~~ 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.
Surprise Billing Protection Form, page 1	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.**
Surprise Billing Protection Form, page 1	Deleted (edited and moved to the preceding sentence): ~~**Getting care from this provider or facility could cost you more.**~~
Surprise Billing Protection Form, page 1	If your plan covers the item or service you're getting, federal law protects you from higher bills when: • ~~When you get~~ You're getting emergency care from an out-of-network ~~providers and facilities~~ provider or facility, or • ~~When an~~ An out-of-network provider ~~treats~~ is treating you at an in-network hospital or ambulatory surgical center without ~~your knowledge or~~ getting your consent to receive a higher bill.
Surprise Billing Protection Form, page 1	Ask your health care provider or patient advocate if ~~you need help knowing~~ you're not sure if these protections apply to you.
Surprise Billing Protection Form, page 1	If you sign this form, be aware that you may pay more because: • ~~You are~~ You're giving up your legal protections from higher bills ~~under the law~~. • You may owe the full costs billed for the items and services ~~received~~ 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.

Surprise Billing Protection Form, page 1	Deleted: ~~You shouldn't sign this form if you didn't have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.~~
Surprise Billing Protection Form, page 1	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 ~~might~~ if they can work out an agreement with this provider or facility~~,~~ (or another one) to lower your costs.
Surprise Billing Protection Form, page 2	**Estimate of what you could pay if you give up your protections**
Surprise Billing Protection Form, page 2	►**Call your health plan**. Your plan may have better information about how much ~~you will~~ you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.
Surprise Billing Protection Form, page 2	►**Questions about this notice and estimate?** ~~Call~~ 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.]
Surprise Billing Protection Form, page 2	►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]
Surprise Billing Protection Form, page 2	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 ~~an item or service~~ the items or services before you can get them. If your plan requires prior authorization ~~is required~~, ask ~~your health plan about~~ them what information ~~is necessary~~ they need for you to get coverage.]
Surprise Billing Protection Form, page 2	You can ~~also~~ get the items or services described in this notice from ~~these~~ the following providers who are in-network with your health plan:
Surprise Billing Protection Form, page 2	Visit [~~website~~ Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers] for more information about your rights under federal law.
Surprise Billing Protection Form, page 3	**By signing, I ~~give~~ understand that I'm giving up my federal consumer protections and ~~agree~~ may have to pay more for out-of-network care.**
Surprise Billing Protection Form, page 3	With my signature, ~~I am saying that I agree~~ I'm agreeing to get the items or services from (select all that apply):
Surprise Billing Protection Form, page 3	With my signature, I acknowledge that ~~I am~~ I'm consenting of my own free will and ~~am~~ I'm not being coerced or pressured. I also ~~understand~~ acknowledge that: • I'm giving up some consumer billing protections under federal law.

	• I may ~~get a bill for~~ 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 ~~explaining that~~ explained my provider or facility isn't in my health plan's network, described the estimated cost of ~~services~~ 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.
Surprise Billing Protection Form, page 3	**IMPORTANT: You don't have to sign this form. ~~But if~~ If you don't sign, this provider or facility might not treat you~~. You~~, but you can choose to get care from a provider or facility that's in your health plan's network.**
Surprise Billing Protection Form, page 4	**More details about your total cost estimate**
Surprise Billing Protection Form, page 4	**Contact your health plan to find out ~~how much, if any,~~ if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.**
Surprise Billing Protection Form, page 4	*[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.]~~.~~*
Surprise Billing Protection Form, page 4	*[~~Populate~~ For each provider or facility described in the notice, fill-in the table below ~~with~~ by completing each column for each item and service~~, date of service, and estimated cost~~ 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.]*
Surprise Billing Protection Form, page 4 (table)	Column added: **Name of Provider or Facility**
Surprise Billing Protection Form, page 4 (table)	Additional row added: **Subtotal for [insert name of provider or facility]**

The following changes were made to the Model Disclosure Notice Regarding Patient Protections Against Surprise Billing:

Section Edited	Revision (Red indicates modified Language)
Instructions for Providers and Facilities, page 1	Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes the following information in clear and understandable language ~~on~~: (1) the federal restrictions on providers and facilities regarding balance billing in certain circumstances, (2) any applicable state law protections against balance billing, and (3) information on contacting appropriate state and federal agencies ~~in the case that~~ if an individual believes ~~that~~ a provider or facility has violated the restrictions against balance billing.
Instructions for Providers and Facilities, page 1	Health care providers and facilities ~~may~~ can, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review, ~~and~~ complete, and provide it in a manner consistent with applicable state and federal law. HHS considers use of this model notice, in accordance with these instructions, to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met.
Instructions for Providers and Facilities, page 1	If a state develops model or required language for its disclosure notice that is consistent with section 2799B-3 of the PHS Act, HHS will consider a provider or facility that makes good faith use of the state-developed ~~model~~ language ~~to be~~ compliant with the federal requirement to include information about state law protections.
Instructions for Providers and Facilities, pages 1-2	**Public ~~Disclosure Requirements~~ disclosure requirements** The disclosure notice must be publicly available, and ~~if applicable)~~ posted on a provider's or facility's website (if applicable). - **To ~~satisfy~~ meet the public disclosure requirement**, providers and facilities must prominently display a sign with the required disclosure information in a location of the provider or facility~~,~~ (such as~~,~~ where individuals schedule care, check-in for appointments, or pay bills), unless the provider doesn't have a publicly accessible location. - **To ~~satisfy~~ meet the separate requirement to post the disclosure on a public website**, the disclosure or a link to the disclosure must ~~appear~~ be on a searchable homepage of the provider's or facility's public website.

Instructions for Providers and Facilities, page 2	**Who should get this notice** In general, providers and facilities must give the disclosure notice to individuals who are: • ~~Participants~~ Participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, including covered individuals in a health benefits plan under the Federal Employees Health Benefits Program, and • ~~to~~ To whom ~~they~~ the provider or facility ~~furnish~~ furnishes items or services, ~~and then~~ but only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility. Providers and facilities shouldn't give these documents to an individual who has Medicare, Medicaid, or any form of coverage other than previously described, or to an individual who is uninsured.
Instructions for Providers and Facilities, page 2	~~**Provision of the**~~ **Providing this notice** Providers and facilities must provide the notice in-person, by mail, or ~~via~~ by email, as selected by the individual. The disclosure notice must be limited to ~~one page (double-sided)~~ one, double-sided page and must use a 12-point font size ~~of 12 points~~ or larger. Providers and facilities must issue the disclosure notice no later than the date and time ~~on which~~ they request payment from the individual (including requests for copayment or coinsurance made at the time of a visit to the provider or facility). If the provider or facility doesn't request payment from the individual, they must provide the notice ~~must be provided~~ no later than the date ~~on which the provider or facility submits~~ they submit a claim for payment to the plan or issuer.
Instructions for Providers and Facilities, page 2	Deleted (edited and moved below): ~~**Use of Plain Language**~~ ~~Health care providers, facilities, plans, and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.~~ ~~Plain language, accessibility, and language access resources:~~ ~~Plainlanguage.gov/guidelines~~ ~~Section508.gov~~ ~~LEP.gov~~
Instructions for Providers and Facilities, pages 2-3	**Compliance with Federal Civil Rights Laws** Entities that ~~receive~~ get federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI 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. Sections 1557 and ~~section~~ 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Providers and facilities are reminded that the disclosure notice must comply with applicable state or federal language-access standards.
Instructions for Providers and Facilities, page 3	Added (edited and moved from above): **Use of plain language** Health care providers and facilities are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible. Plain language, accessibility, and language access resources: - Plainlanguage.gov/guidelines - Section508.gov - LEP.gov
Instructions for Providers and Facilities, page 3	**NOTE**: The information provided in these instructions is intended to be only a general summary of technical legal standards. It ~~is not~~ isn't intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.
Instructions for Providers and Facilities, page 3	**~~DO NOT~~ DON'T INCLUDE THESE INSTRUCTIONS WITH THE DISCLOSURE NOTICE ~~PROVIDED~~ GIVEN TO PATIENTS.**
Instructions for Group Health Plans and Health Insurance Issuers, page 1	Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

	(1) the federal restrictions on balance billing in certain circumstances, (2) any applicable state law protections against balance billing, (3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and (4) information on contacting appropriate state and federal agencies ~~in the case that~~ if an individual believes ~~that~~ a provider or facility has violated the restrictions against balance billing.[1]
Instructions for Group Health Plans and Health Insurance Issuers, page 1	Plans and issuers ~~may~~ can, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review, ~~and~~ complete, and provide it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) ~~will~~ consider use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.
Instructions for Group Health Plans and Health Insurance Issuers, page 1	If a state develops model or required language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed ~~model~~ language ~~to be~~ compliant with the federal requirement to include information about state law protections.
Instructions for Group Health Plans and Health Insurance Issuers, pages 1-2	Deleted and moved below: ~~**Use of Plain Language**~~ ~~Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.~~ ~~Plain language, accessibility, and language access resources:~~ ~~Plainlanguage.gov/guidelines~~ ~~Section508.gov~~ ~~LEP.gov~~
Instructions for Group Health Plans and Health Insurance Issuers, pages 1-2	**Compliance with Federal Civil Rights Laws** Entities that ~~receive~~ get federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with

[1] Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

	limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English. Sections 1557 and ~~section~~ 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Plans and issuers are reminded that the disclosure notice must comply with applicable state or federal language-access standards.
Instructions for Group Health Plans and Health Insurance Issuers, page 2	Moved from above: **Use of Plain Language** Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible. Plain language, accessibility, and language access resources: - Plainlanguage.gov/guidelines - Section508.gov - LEP.gov
Instructions for Group Health Plans and Health Insurance Issuers, page 2	**NOTE**: The information provided in these instructions is intended to be only a general summary of technical legal standards. It ~~is not~~ isn't intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.
Instructions for Group Health Plans and Health Insurance Issuers, page 2	**~~DO NOT~~ DON'T INCLUDE THESE INSTRUCTIONS WITH THE DISCLOSURE NOTICE ~~PROVIDED~~ GIVEN TO PARTICIPANTS, BENEFICIARIES, OR ENROLLEES.**
Your Rights and Protections Against Surprise Medical Bills, page 1 (box)	When you get emergency care or ~~get~~ are 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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.
Your Rights and Protections Against Surprise Medical Bills, page 1	Added link to definition in Healthcare.gov glossary for: out-of-pocket costs, copayment, coinsurance, and deductible: When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, ~~such as~~ like a copayment, coinsurance,

	~~and/or a~~ or deductible. You may have ~~other~~ 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.
Your Rights and Protections Against Surprise Medical Bills, page 1	"Out-of-network" ~~describes~~ means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be ~~permitted~~ allowed to bill you for the difference between what your plan ~~agreed to pay~~ 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.
Your Rights and Protections Against Surprise Medical Bills, page 1	"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.
Your Rights and Protections Against Surprise Medical Bills, page 1	**~~You are~~ You're protected from balance billing for:**
Your Rights and Protections Against Surprise Medical Bills, page 1	**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~~ they can bill you is your plan's in-network cost-sharing amount (such as copayments, ~~and~~ 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 balanced billed for these post-stabilization services.
Your Rights and Protections Against Surprise Medical Bills, page 1	[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed ~~model~~ language as appropriate*]
Your Rights and Protections Against Surprise Medical Bills, pages 1-2	**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~~ 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.

Your Rights and Protections Against Surprise Medical Bills, page 2	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.
Your Rights and Protections Against Surprise Medical Bills, page 2	**You're never required to give up your protections from balance billing. You also aren't required to get ~~care~~ out-of-network care. You can choose a provider or facility in your plan's network.**
Your Rights and Protections Against Surprise Medical Bills, page 2	[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed ~~model~~ language regarding applicable state law requirements as appropriate*]
Your Rights and Protections Against Surprise Medical Bills, page 2	**When balance billing isn't allowed, you also have ~~the following~~ these protections:** • ~~You are~~ You're only responsible for paying your share of the cost (like the copayments, coinsurance, and ~~deductibles~~ 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~~ your health plan ~~generally~~ must: o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization"). o Cover emergency services by out-of-network providers. o 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. o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.
Your Rights and Protections Against Surprise Medical Bills, page 2	**If you ~~believe~~ think you've been wrongly billed**, ~~you may~~ contact [*~~applicable~~ Insert 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 [*Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers*] for more information about your rights under federal law. [*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]