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.

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- **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 consumers 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 "Copay") –** 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.

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.

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- **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 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.

- **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.