§ 149.130 Preventing surprise medical bills for air ambulance services.

(a) *In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan or issuer described in paragraph (a) of this section must provide coverage of air ambulance services in the following manner—

(1) The cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services.

(2) The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount (as determined in accordance with § 149.140) or the billed amount for the services.

(3) The cost-sharing amounts must be counted towards any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to services furnished by a participating provider of air ambulance services.

(4) The plan or issuer must—

(i) Not later than 30 calendar days after the bill for the services is transmitted by the provider of air ambulance services, determine whether the services are covered under the plan or coverage and, if the services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(4)(i), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

(ii) Pay a total plan or coverage payment directly to the nonparticipating provider furnishing such air ambulance services that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(1) and (2) of this section), less any initial payment amount made under paragraph (b)(4)(i) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 2799A-2(b)(6) of the PHS Act, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.