Your Rights and Protections Against Surprise Medical Bills

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

What types of plans do these rights and protections apply to?

- Self-funded health benefit plans, including state government and municipal health benefit plans
- Fully insured health benefit plans
- Federal Employees Health Benefit Plan (FEHBP)
- Grandfathered Health Plans
- If you are not sure what type of plan you have, contact us, we're here to help you!

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 must 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 allowed 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. Examples are 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.

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

- You are only responsible for paying your share of the cost, such as 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.
- You're never required to give up your protections from balance billing. You also don't have to get care out-of-network. You can choose a provider or facility in your plan's network.

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. This includes copayments, deductibles and

coinsurance. You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition. The exception is if you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain services performed by an out of network provider at an in-network hospital or ambulatory surgical center**
  When you get services from certain out-of-network providers at an in-network hospital or ambulatory surgical center, those out-of-network providers may not balance bill you or ask you to sign a written notice and consent form that allows balance billing. You pay only your plan's in-network cost sharing amount. This applies to anesthesia, assistant surgeon, emergency medicine, hospitalist, intensivist service, laboratory, neonatology, pathology, or radiology.

  If you get **other services from any other out-of-network providers** at in an in-network hospital or ambulatory surgical center, these out-of-network providers **can't** balance bill you, unless you sign a written notice and consent form that allows balance billing and are provided with a good faith estimate of your costs from the hospital or ambulatory surgical center before services are given. If you sign the notice and consent form, you can be balance billed for out-of-network services. **You are not required to sign the notice and consent form. You may seek care from an available in-network provider.**

- **Air Ambulance**
  When you receive medically necessary air ambulance services from an out-of-network provider, your cost share will be the same amount that you would pay if the service was provided by an in-network provider. Any coinsurance or deductible will be based on rates that would apply if the services were supplied by an in-network provider.

Some states have surprise bill/balance billing laws. These laws apply to fully insured plans and may have impact to some self-funded plans, including state government or municipal plans and church plans. Check with your plan administrator and/or booklet to find if state law applies to your coverage.

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 send complaints about potential violations of federal law or state law to:

- The U.S. Department of Health & Human Services at:
  - Phone: 800-985-3059
  - Website: https://www.cms.gov/nosurprises/consumers.
- Your state agency, which can be located State Contacts for Fed NSA

How to handle services supplied based on inaccurate provider directory information?
If you relied on inaccurate information from our provider directories or website or that we verbally provided, we hold you harmless. For example, if you received services from a provider that you believed was in-network based on inaccurate information showing that the provider was in-network, but your claim was paid as out-of-network. In these situations, contact us and we will review the claim. After review, you may be responsible only for your in-network cost share.