Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have 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.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan 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.

"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.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, 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.

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 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.

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.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

You are also protected from out of network balance billing under the laws of the **State of New Jersey**. A summary of these protections is attached as an addendum to this disclosure notice.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and 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 health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at *1-800-985-3059*.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

Surprise Medical Bills

Summary of New Jersey State Law

Out-of-network Balance Billing Protection: Under New Jersey law, healthcare providers are prohibited from balance billing a covered person for *inadvertent out-of-network services* and/or out-of-network services provided on an *emergency or urgent basis* above the amount of the covered person's liability for in-network cost-sharing (i.e., the covered person's network level deductible, copayments, and coinsurance).

- "Inadvertent out-of-network services," means health care services that are covered under a health benefits plan that provides a network, and are provided by an out-of-network health care provider in an in-network health care facility when in-network health care services are unavailable in that facility or are not made available to the covered person. "Inadvertent out-of-network services" also includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory; and

- "Emergency or urgent basis" means all emergency and urgent care services.

Any attempts by the out-of-network healthcare provider to bill the covered person for these types of services above the covered person's in-network cost-sharing liability should be reported to the covered person's carrier, and a complaint may be filed with the appropriate provider's licensing board or other regulatory body, as appropriate. A complaint may also be filed with the New Jersey Department of Banking and Insurance.

Please do not hesitate to visit the State of New Jersey's website at https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html for more information about your rights under the laws of the State of New Jersey.