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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care, use an out-of-network air ambulance provider, or get 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.

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 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted 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 as defined by a new federal law called the No Surprises Act. 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.

The No Surprises Act protects you 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 (such as copayments and coinsurance). We will pay out-of-network providers the amount we owe under the No Surprises Act.

You can't be balance billed above the in-network cost- sharing amount 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 covered 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 bill you is your plan's in-network cost-sharing amount shown on the explanation of benefits. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology,

assistant surgeon, hospitalist, or intensivist services. We will pay out-of-network providers the amount we owe under the No Surprises Act.

These providers **can't** balance bill you above the in-network cost-sharing amount shown on the explanation of benefits and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, for example from the primary surgeon or oncologist, out-of-network providers **can't** balance bill you above the in-network cost-sharing amount shown on the explanation of benefits, unless you give written consent and give up your protections.

Out-of-Network Air Ambulance Services

When you get covered services from an out-of-network air ambulance provider (rotary or fixed wing), we will pay the out-of-network provider the amount we owe under the No Surprises Act.

These providers can't balance bill you above the in-network cost-sharing amount shown on the explanation of benefits and may not ask you to give up your protections not to be balance billed.

You're never required to give up your protections from balance billing under the No Surprises Act. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network) shown on the explanation of benefits. Your health plan will pay out-of-network providers and facilities directly. If you have any questions about these amounts, please contact us at 973-423-4565.

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 contact the federal government's No Surprises Helpdesk at 1-800-985-3059. If you have questions about the explanation of benefits, please contact us at 973-423-4565.

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