Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

(1) the restrictions on balance billing in certain circumstances,
(2) any applicable state law protections against balance billing,
(3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care 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.

Definitions:

Surprise billing: occurs when people unknowingly get care from providers that are out-of-network with their health insurance plan and consequently receive an unexpected 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.

Balance billing: occurs when people are billed for the difference between the provider's full charge and your health insurance plan's approved amount.

In-network hospital: means the hospital is contracted with your health insurance plan and has negotiated discounted rates for services.

Out of network provider: means that the clinician/medical provider does not have a contract with your health insurance plan. Services may cost more or not be covered at all by your plan.

Example: Patient requires services through the Emergency Room and lives out of State and the ER Provider and Hospital does not participate with your Health Plan. Patient typically has an ER copay of $50.00 but due to the Provider being out of network, your health plan applies $150.00 copay. The Provider will only bill the patient for the In-Network rate of the $50.00 copay.

Assumptions: Don't assume that all insurances are In-Network. Patients need to know their Health Plan.

After you sign up for your health insurance plan, your next step should be to locate an in-network emergency room and urgent care facility and select a primary care doctor. Verify with your health insurance company that they are in-network. Remember to check that the doctors who practice at the

facility are in-network. Write this information down where it is easily accessible—in a planner, on your phone, on a piece of paper stuck to the fridge – and make sure those you live with know this information. If you are unable to direct where you are taken, these individuals may be able to do so.

How would we (BMH) know? Always obtain a copy of the Patient's Insurance Card. Patients can verify if their Health Plan is In-Network or Out-of-Network, it is the best way to know. Most Insurance Cards will show the Patient's out-of-pocket expenses for ER, Specialty, and PCP visits.

You are protected from balance billing:

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). 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.

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

• These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills.
• No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420

Exceptions to no balance billing for out-of-network emergency services – notice & consent

Nonparticipating providers and facilities may balance bill for post stabilization services only if all of the following conditions have been met:
• The attending emergency physician or treating provider determines that the beneficiary, enrollee or participant:

1. Can travel using non-medical or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition; and
2. Is in a condition to receive notice and provide informed consent.
3. The nonparticipating provider or facility provides the beneficiary, enrollee or participant with a written notice and obtains consent that includes certain content and within a specific timeframe and format outlined in regulation and guidance. See resource slide for link to the regulation and required forms for the notice and consent documents.
4. The provider or facility satisfies any additional state law requirements.

If you believe you've been wrongly billed, you may contact The HHS No Surprises Help desk at 1-800-985-3059 or, www.cms.gov/nosurprises/consumers