NO SURPRISES ACT

Effective January 1, 2022, the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts.

BILLING DISCLOSURES – 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. In this cases, you should not 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, such as a copayment, coinsurance, and/or a 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 is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not 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 the 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.

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 (such as copayments, coinsurance and deductibles). You cannot be balance billed for these emergency services. This includes services you may get after you are 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 may 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 cannot balance bill you 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, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

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

You may also be protected from out-of-network balance billing under the laws of the State of New Jersey. A summary of these protections follows as an addendum to this disclosure notice.

WHEN BALANCE BILLING IS NOT 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 were in- network). Your health plan will pay 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 (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.

GET MORE INFORMATION

If you think you have been wrongly billed you may contact the Centers for Medicare & Medicaid Services, Department of Health and Human Services No Surprises Help Desk at 1-800-985-3059.

For more information about your rights under federal law, visit www.cms.gov/nosurprises/consumers.

SUMMARY OF NEW JERSEY OUT-OF-NETWORK BALANCE BILLING PROTECTIONS

New Jersey law prohibits out-of-network providers and health care facilities in New Jersey from balance billing patients in excess of the patient's deductible, copayment, or coinsurance amount applicable to in-network services for (i) emergency or urgent medically necessary services, and (ii) inadvertent out-of-network services. New Jersey law defines "inadvertent out-of-network services" as health care services (1) covered under a managed care health benefits plan that provides a network; and (2) provided by an out-of-network provider at an in-network health care facility when in-network services are unavailable at that facility or are not made available to you at the facility. This protection applies to all carriers operating in New Jersey with regards to health benefits plans issued in New Jersey, including self-funded plans that opt-into New Jersey's law.

Any attempts by an out-of-network healthcare provider to bill you for these types of services above your in-network cost-sharing liability may be reported to your health plan, and a complaint may be filed with your provider's licensing board, or other regulatory authority. A complaint may also be filed with the New Jersey Department of Banking and Insurance.

For information about your rights under this New Jersey law, visit https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html.

YOUR RIGHT TO RECEIVE A GOOD FAITH ESTIMATE

Under the federal No Surprises Act, health care providers are required to give patients who are uninsured or who are not using insurance an estimate of their bill for healthcare items and services before those items ore services are provided.

Specifically under the law, if you are uninsured or are not using insurance for your healthcare services, you have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

If you schedule a health care item or service at least 3 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing at least 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask your healthcare provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.