Balance Billing Restrictions Notice
(For use beginning January 1, 2023)

Instructions

The No Surprises Act requires plans to notify participants that balance billing is prohibited for certain specified services. This notification must be (1) made publicly available, (2) posted on the plan's public website, and (3) included in each explanation of benefits issued for No Surprises Act services. The Departments of Labor and Health and Human Services have developed a model notice that the Plan may use to satisfy this requirement. The Departments consider appropriate use of the model notice to be good faith compliance with the disclosure requirements of section 9820(c) of the Internal Revenue Code, and section 720(c) of the Employee Retirement Income Security Act.

The Plan should post this notice on its website and include with EOBs issued for No Surprises Act services. Until further guidance is issued clarifying how plans should make the notice publicly available, posting the notice on the Plan's website should demonstrate good faith compliance.

This notice has been slightly modified from the original to reflect that the Plan is self-funded. Self-funded plans are generally exempt from state balance billing laws.

We have also prepared a condensed version of the notice that can be used on No Surprises Act EOBs in lieu of the full notice if the Plan determines that adding the full notice to EOBs would be administratively burdensome. This modified version includes the required elements of the notice. Unless and until further guidance is issued, the condensed language seems to be a reasonable, good faith interpretation of the guidance.

> You are entitled to certain protections against balance billing under the No Surprises Act. When you: (i) receive emergency care (other than ground ambulance services) from an out-of-network provider, facility or air ambulance, or (ii) are treated by certain out-of-network providers at an in-network hospital or ambulatory surgical center, you cannot be billed more than the Plan's in-network cost-sharing amounts. In some cases providers may request that you provide written consent and give up your protections. **You are never required to give up your protections from balance billing.**
>
> You remain responsible for paying your share of the cost for these services (like copayments, coinsurance, and deductibles) as if they were received at an in-network provider or facility. The Plan will count any amount you pay toward your in-network deductible and out-of-pocket limit. The Plan covers emergency services by out-of-network providers and does not require you to receive prior authorization for emergency services.
>
> If you think you've been wrongly billed, you can contact the Department of Health and Human Services (HHS) via its toll-free number at 1-800-985-3059. You can also visit https://www.cms.gov/nosurprises/consumers or the [Plan/Fund] website for more information about your rights under federal law.

NOTE: The Plan should *not* include this instruction page with the model Balance Billing Restrictions notice.

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care (other than ground ambulance services) or are 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 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 (referred to as "cost-sharing amounts"). 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 the Plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract to participate in the Plan's network 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 does not count toward your in-network 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 (other than ground ambulance services) from an out-of-network provider, facility, or air ambulance, the most they can bill you is the Plan's in-network cost-sharing amounts. You **can't** be balance billed for these emergency services. This includes services you may receive 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 receive 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 the 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 receive other types of services at an in-network facility, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You are <u>never</u> 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 the Plan's network.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're 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). The Plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, the Plan will:

    - 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) for these services on what the Plan 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 these out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the Department of Health and Human Services (HHS) via its toll-free number at 1-800-985-3059.

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