ENGLEWOOD HEALTH

Your Rights and Protection 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 should not be charged more than your plan's copayments, coinsurance and/or deductible. This disclosure notice does not apply to patients covered by Medicare, Medicaid, Veterans Affairs Health Care, Indian Health Services, Tricare, Medicare Advantage Plans, Managed Medicaid Plans, Workers Compensation, or No Fault.

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 is not in your health plan's network.

"Out-of-network" means providers and facilities that have not 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 cannot 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 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 they can 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 balance billed for these post-stabilization services.

The New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act (P.L.2018, c32) (the Act), prohibits out-of-network providers, including professionals and facilities from balance billing patients beyond in-network cost shares 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 health benefits plan with a provider 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. This protection applies to all carriers operating in New Jersey for health benefits plans issued in New Jersey.

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 cannot balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of 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 protection from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have these protections:

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

For services rendered in New Jersey, you may also contact the New Jersey Department of Banking and Insurance at 609-292-7272 or file an online complaint at: www.state.nj.us/dobi/consumer.htm

Visit www.cms.gov/nosurprises/consumers for your rights under federal law.

Visit www.state.nj.us/dobi/index.html for your rights under state law.