

No Surprises Act

This notice applies only to Medical benefits.

YOUR RIGHTS AND PROTECTIONS 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.

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 isn't 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 receive 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 cannot be balance billed for these emergency services. This includes services you may receive 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 receive certain services from an in-network hospital or ambulatory surgical center, certain providers at that facility 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, anesthesiology, pathology, radiology, laboratory services, neonatology, assistant surgeon

services, hospitalist services, 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 receive 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 protections 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 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). Your plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your plan must:
 - Cover emergency services without requiring you to receive approval for services in advance (also known as “prior authorization”).
 - Cover emergency services performed by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) 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 out-of-network services toward any in-network deductible and out-of-pocket limit that may apply.

If you think you have been wrongly billed, you may contact the Department of Health and Human Services (HHS) by calling 1-800-985-3059. You may visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

If you are an employee in New York or Illinois and participate in an insured plan, you may have additional rights under state law.

New York Residents

If you believe that you have been improperly charged for a surprise bill by a health care provider, or that a health plan has improperly assessed cost sharing for a surprise bill, you can file a complaint with the Health Care Bureau online at, <https://ag.ny.gov/file-complaint>, or call the Attorney General’s Health Care Helpline at 1-800-428-9071.

Illinois Residents

If you believe that that you have been wrongly charged, you may file a complaint online with the Illinois Department of Insurance by visiting, <https://doi.illinois.gov/consumers/file-a-complaint.html>, or by calling the Consumer Assistance line at 866-445-5364.