

Member Rights and Protections Against Surprise Medical Bills

When you get emergency care, use an out-of-network air ambulance provider, 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.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider or use an air ambulance provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in our network. See Sections 1 and 3 of this plan's Brochure.

“Out-of-network” describes providers and facilities that haven't signed a contract with this plan. Out-of-network providers may be permitted to bill you for the difference between what we agreed to pay 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 annual out-of-pocket limit. See Section 4 of this plan's Brochure.

“Surprise billing” is an unexpected balance bill as defined by a new federal law called the No Surprises Act. 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.

Note that the protections described in this notice that relate to out-of-network providers only apply to charges from non-PPO facilities and providers that do not have agreements with this plan. Some facilities and providers are considered “non-PPO” under our plan Brochure but are not “out-of-network” for purposes of the No Surprises Act if they are contracted with this plan's non-directed networks (Multiplan or Zelis (formerly Stratose)). See Section 1 of this plan's Brochure.

The No Surprises Act protects you from surprise 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 shown on the explanation of benefits. We will pay out-of-network providers the amount we owe under the No Surprises Act.

You can't be balance billed above the in-network cost-sharing amount 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 balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get covered 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 shown on the explanation of benefits. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. We will pay out-of-network providers the amount we owe under the No Surprises Act.

These providers **can't** balance bill you above the in-network cost-sharing amount shown on the explanation of benefits 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, for example from the primary surgeon or oncologist, out-of-network providers **can't** balance bill you above the in-network cost-sharing amount shown on the explanation of benefits, unless you give written consent and give up your protections.

Out-of-Network Air Ambulance Services

When you get covered services from an out-of-network air ambulance provider (rotary or fixed wing), we will pay the out-of-network provider the amount we owe under the No Surprises Act.

These providers **can't** balance bill you above the in-network cost-sharing amount shown on the explanation of benefits and may not **ask** you to give up your protections not to be balance billed.

You're never required to give up your protections from balance billing under the No Surprises Act. You also aren't required to get care out-of-network. You can choose a provider or facility in this plan's network. See Section 4 of this plan's brochure.

When balance billing isn't 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) shown on the explanation of benefits. Your plan will pay out-of-network providers and facilities directly as shown on the explanation of benefits. If you have any questions about these amounts, please contact us at **888-636-6252 (NALC)**.

Your plan generally 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.

If you believe you've been wrongly billed by the provider, you may contact the federal government's No Surprises Helpdesk at 1-800-985-3059. If you have questions about the explanation of benefits, please contact us at **888-636-6252 (NALC)**.

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