Your Rights and Protections Against Surprise Medical Bills

Beginning January 1, 2022, Federal law protects you from 'surprise billing' or 'balance billing' if you receive covered emergency care or are treated at an in-network hospital or outpatient surgical facility in Guam, CNMI, or Continental US.

On December 27, 2020, US Congress passed the No Surprises Act of 2021 under Title I of the 2021 Consolidated Appropriations Act which seeks to protect consumers against surprise medical billing at certain out-of-network providers. Under your StayWell health insurance plan, you are entitled to coverage for services rendered at StayWell's network of providers otherwise known as "in-network" providers. Should you receive services at providers and facilities that are not part of your plan called "Out-of-network" providers, typically these providers will charge a higher amount for the same services offered within our network. The No Surprises Act is designed to protect consumers like you from paying exorbitant costs at such providers by effectively ending the practice of surprise or balance billing.

According to the Centers for Medicare & Medicaid Services, payments made to providers/facilities by people who received a surprise bill for emergency care were more than ten times higher than those made by other individuals for the same care. In addition, studies have shown that in the period from 2010-2016, more than 39% of emergency department visits to in-network hospitals resulted in surprise bills, increasing to 42.8% in 2016. During the same period, the average amount of a surprise medical bill also increased from $220 to $628.

In addition to protecting consumers, the balance billing provisions in the No Surprises Act have the potential to decrease health care spending, despite administrative burdens. When the rules become effective, they will provide patients immediate protections against balance bills, reducing their exposure to out-of-pocket medical expenses.

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 other 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 or "Out-of-network" provider.

"Out-of-network" describes providers and facilities that haven't 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 in-network costs for the same service and might not count toward your 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" and **can not** be balanced billed 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 and coinsurance). You can't be balance billed for emergency or certain post stabilization services, unless you give written consent and give up your protections not to be balanced billed.

- **Certain services at an in-network hospital or ambulatory surgical center**
  If you receive services from an in-network hospital or ambulatory surgical center, and certain providers that may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount. This includes, but is not limited 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.

You're never required to give up your protections from balance billing. You also aren't required to get care at an out-of-network provider. You can choose a provider or facility in your plan's network. If you believe you've been wrongly billed or would like additional information, you may contact The Department of Health and Human Services (HHS) at 1-800-985-3059 or visit their website www.cms.gov/nosurprises

You also have the following protections and responsibilities:

- You will be responsible for paying your share of the cost and services like copayments, coinsurance, deductibles, services subject to plan limitations and exclusions that you would pay if the provider or facility was in-network. Your health plan will pay out-of-network providers and facilities directly.

Source: Centers for Medicare and Medicaid Services

- Your health 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.

SW-NSBD 12/21