No Surprises Act

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

The No Surprises Act is a federal rule, effective January 1, 2022, created to protect consumers from surprise health care bills. This Act requires medical workers, clinical social workers, and other health care providers to notify consumers of their federally protected rights and to provide consumers with a good faith estimate (GFE) of expected charges that may be billed for these items or services when:

- patient services are rendered by an out-of-network provider
- Uninsured patients (e.g., not enrolled in any health plan or coverage)
- Patients elect not to use their insurance (e.g., self-pay or not seeking to file a claim with their plan or coverage)

The GFE must be provided both orally and in writing, upon request or at the time of scheduling health care items and services and within specific timeframes.

This Act applies to both current and future patients who fit these guidelines.
The notifications and GFEs do not need to be provided to patients who are enrolled in federal health insurance plans (e.g., Medicare, Medicaid, TRICARE, Indian Health Service, or the Veterans Affairs health system). The notifications and GFEs also do not yet apply to other insurance plans when a consumer or client is working with in-network providers and using in-network insurance to pay for medical services.
You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Additional information related to the No Surprises Act

"Balance billing" is 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.

"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 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 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 balanced billed for these post-stabilization services.

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 may 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 **can't** balance bill you 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, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

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). Your health plan will pay out-of-network providers and facilities directly.
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
- 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
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket.

If you believe you've been wrongly billed, you may visit https://www.cms.gov/nosurprises or call 800-985-3059

Other Resources:
Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under Federal law.

https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html for more information about your rights under New Jersey State law.