Your Rights and Protections Against "Surprise" Medical Bills

When you get emergency care or get treated by an "out of network" provider at an "in-network" hospital or ambulatory surgery 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 healthcare provider, you **may owe** certain out of pocket costs, such as a **co-payment, coinsurance, and/or deductible**. You may have other costs or **have to pay the entire bill** if you see a provider or visit a healthcare 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 co-payments and coinsurance**). You **cannot 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 bill** 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 may be **"out of network". In these cases,** the most those providers **may bill** 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 balance billed.

If you get other services at these **"in network"** facilities, **"our of network"** providers **cannot** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also are not required to get care "out of network". You can choose a provider or facility in your plan's network.

New Jersey comprehensive balance billing protections requires insurers to hold enrollees harmless for amounts beyond **"in-network"** level of cost sharing and **prohibits "out of network"** providers from billing enrollees of any amount beyond "in-network" level of cost sharing emergency services provided

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by **"out of network"** professionals and facilities, non-emergency services provided by **"out of network"** professionals as "in-network" facilities provided by all or most classes of health care professionals. New

Jersey law also provides a dispute resolution process. The above mentioned protections do not apply to non-emergency services when "in-network" services are available in that facility and enrollee signs a consent form agreeing to services by a specific **"out of network"** professional instead.

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 co-payments, coinsurance, and/or 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" 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 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 have been wrongly billed, you may contact the Department of Health and Human Services: 1-800-985-3059 or State of New Jersey Department of Banking and Insurance: 1-800-446-7467.

Visit **https://www.cms.gov/nosurprises** for more information about your rights under Federal Law
Visit **https://www.state.nj.us/dobi/index.html** for more information about your rights under State law.

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