YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

What is "balance billing" (sometimes called "surprise billing")?

"**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**." "**Surprise billing**" is an unexpected balance bill, such as when an out-of-network provider provides a service at visit at an in-network facility. These amounts may be more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

YOU ARE PROTECTED FROM BALANCE BILLING FROM:

Emergency Services

Emergency medical services from an out-of-network provider or facility may not bill you more than 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 for these post-stabilization services. This also includes services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

Unless you are given notice and provide written consent to the contrary, an out-of-network provider at an in-network hospital or ambulatory surgical center may not bill you more than your plan's in-network cost-sharing amount. However, the following providers cannot balance bill you, even with written consent: **emergency medicine**, **anesthesia**, **pathology**, **radiology**, **laboratory**, **neonatology**, **assistant surgeon**, **hospitalist**, or **intensivist services**. Additionally, your doctor must provide you with the **name**, **practice name**, **mailing address**, and **telephone number** of any out-of-network health care provider scheduled to perform these services.

Your provider, to the extent such information is available, must also provide you with instructions to as to how to determine the health benefits plans in which he or she participates. Upon written request from you, your provider must give you the estimated amount that you will be billed for the service and the CPT codes associated with that service.

COVERAGE BY YOUR INSURER

Unless you provide written consent to the contrary, you are only responsible for paying your share of the cost (copayments, coinsurance, deductibles, etc.) **Your health plan generally must**: i) cover emergency services without requiring you to get prior authorization; ii) cover emergency services by out-of-network providers; iii) base your cost-sharing expenses on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB); and, iv) count any amount you pay for out-of-network services toward your deductible and out-of-pocket limit.

You should always contact your insurer regarding your coverage status and payment obligations prior to undergoing any procedure.

IF YOU BELIEVE YOU'VE BEEN WRONGLY BILLED, you may contact the New Jersey Department of Banking and Insurance ("DOBI") at **www.state.nj.us/dobi/consumer.htm** or the DOBI Consumer Hotline: **1-800-446-7467**.

ADDITIONAL INFORMATION

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

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