LEGAL UPDATE

Revised Surprise Billing Model Notice Now Available

On Aug. 19, 2022, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) jointly released FAQs implementing provisions of the No Surprises Act (NSA), including the requirement that plans and issuers disclose certain balance billing protections to participants. Previously, the Departments released a model notice that could be used to satisfy these disclosure requirements ("Version 1"). **Based on public comments, the Departments revised this model notice ("Version 2") and included it in the appendix of the latest FAQs.**

Disclosure Requirements

For plan years beginning on or after Jan. 1, 2022, the NSA requires group health plans and issuers to make publicly available, post on a public website and include on each applicable explanation of benefits information on the restrictions against balance billing, including any applicable state law protections, and information on contacting appropriate state and federal agencies. The revised notice includes more specific federal agency contact information, along with other minor clarifications.

Employer Compliance Steps

Plans and issuers may, but aren't required to, use the model notice to meet their disclosure obligations. Most employers will rely on their issuers, TPAs or other service providers to fulfill these disclosure requirements. Employers should confirm that their service providers that use the model notice will use Version 2 for plan years beginning on or after Jan. 1, 2023.

In addition, the Departments' FAQs confirm that a health plan that does not have its own website can satisfy the requirement to post the notice by entering into a written agreement where its issuer or TPA agrees to post the notice on a public website where information is normally made available to plan participants on the plan's behalf.

Important Dates

Jan. 1, 2022, to Jan. 1, 2023

The Departments will consider the use of either Version 1 or Version 2 of the model notice to be good faith compliance with respect to plan or policy years beginning on or after Jan. 1, 2022, and before Jan. 1, 2023.

Jan. 1, 2023, and Beyond

The Departments will consider the use of **only** Version 2 of the model notice to be good faith compliance with respect to plan or policy years beginning after Jan. 1, 2023.

The revised notice includes more specific federal agency contact information and can be used in 2022 and beyond.

Provided to you by **Network Insurance Planning Corp.**

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 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, 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.

You're never required to give up your protections 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.

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 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, you may contact your HR department for further assistance.