

Post on the employer's intranet site where medical benefits are addressed, or similar web-based site (such as a benefits administration platform) where employees go for medical benefits information.

If the plan's insurance carrier or third-party administrator posts a surprise billing notice on the carrier's or TPA's website, in the name of the plan where it is accessible by plan members, that posting might be adequate particularly where the plan sponsor does not maintain an intranet site.

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, or from an out-of-network air ambulance service, 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.

For information about state-enacted balance billing protections that might be applicable to you, see the last page of this notice.

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.

For information about *state*-enacted balance billing protections that might be applicable to you, see the last page of this notice.

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 the U.S. Department of Labor's Employee Benefit Security Administration at 1-866-444-3272 or the Health and Human Services Administration at: 1-800-985-3059.

Visit [here](#) for more information about your rights under federal law.

State-enacted balance billing protections that might be applicable to you:

For information about additional, state-enacted surprise billing protections that might be applicable to you, see one or more of the following links for the state in which you live or work. Please note that whether you have protections under state law will depend on whether the state has enacted such protections and the scope of those protections and may also depend on whether your group health insurance benefits are provided under an insured plan, a self-insured plan, or a self-insured plan that has opted into relevant state-enacted protections.

Some of the links below are to a state's general department of insurance website because the state did not have a webpage devoted to surprise billing information at the time this notice was prepared:

Connecticut:

See [here](#) for information about potential surprise billing and other protections under Connecticut law, and [here](#) for information from Connecticut regarding federal protections. In Connecticut, if you believe you've been wrongly billed you may also call the Connecticut Insurance Department at (800) 203-3447.