TEAMCARE
CENTRAL STATES HEALTH FUND

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.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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 Department of Health and Human Services. Visit **cms.gov/nosurprises/consumers** or call 1-800-985-3059 for more information about your rights under federal law.

IMPORTANT TERMS YOU SHOULD KNOW ON YOUR EXPLANATION OF BENEFITS WHEN BALANCE BILLING PROTECTIONS APPLY		EXAMPLE *This example shows how out-of-network claims are processed and how your cost-sharing was determined.*
BILLED AMOUNT:	Total amount the provider billed TeamCare for the services.	**BILLED AMOUNT:** $5,000
ALLOWED AMOUNT:	Benefit amount determined by Plan Section 11.09.	**ALLOWED AMOUNT:** $3,500
QUALIFYING PAYMENT AMOUNT (QPA):	Amount used to calculate any coinsurance you may owe for out-of-network services. The QPA is calculated in accordance with the No Surprises Act.	**QUALIFYING PAYMENT AMOUNT (QPA):** $3,250
DEDUCTIBLE:	Amount of medical expenses that you or your covered dependents pay each calendar year before TeamCare pays certain benefits.	**DEDUCTIBLE:** $200
ELIGIBLE AMOUNT:	Amount after reduction for your *Deductible* (if any) from the *QPA*.	**ELIGIBLE AMOUNT:** $3250 - $200 = $3,050
BENEFIT RATE:	The coinsurance percentage under your benefit plan that determines what the Plan pays for these services.	**BENEFIT RATE:** 80%
NET PAYABLE	The *Eligible Amount* multiplied by the *Benefit Rate* percentage.	**NET PAYABLE** $3,050 x 80% = $2,440
COINSURANCE YOU OWE:	The *Eligible Amount* minus the *Net Payable* amount.	**COINSURANCE YOU OWE:** $3,050 - $2,440 = $610
TOTAL YOU MAY OWE:	Total of copays, *Deductible, Coinsurance You Owe*, and out-of-network deduction (if any).	**TOTAL YOU MAY OWE:** $200 + $610 = $810
PAYABLE BY PLAN:	Is the *Allowed Amount* minus the *Total You May Owe.*	**PAYABLE BY PLAN:** $2,690

Visit MyTeamCare.org for more information on how to read an Explanation of Benefits statement.

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