Your Rights and Protections Against Surprise Medical Bills under the Welfare Benefit Plan

Arch Capital Services LLC

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center or by an air ambulance provider, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional costs or must 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Examples are 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (such as the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- You're never required to give up your protections from balance billing. You also don't have to get out-of-network care. You can choose a provider or facility in your plan's network.

You're 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 they can bill you is your plan's in-network cost-sharing amount. This includes copayments, deductibles and coinsurance. You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition. The exception is if you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain services performed by an out of network provider at an in-network hospital or ambulatory surgical center**
  When you get services from certain out-of-network providers at an in-network hospital or ambulatory surgical center, those out-of-network providers cannot balance bill you or ask you to sign a written notice and consent form that allows balance billing. You pay only your plan's in-network cost-sharing amount. This applies to anesthesia, assistant surgeon, emergency medicine, hospitalist, intensivist service, laboratory, neonatology, pathology, or radiology.

  If you get other types of services from any other out-of-network providers at an in-network hospital or ambulatory surgical center, these out-of-network providers **can't** balance bill you, unless you sign a written notice and consent form that allows balance billing and are provided with a good faith estimate of your costs from the hospital or ambulatory surgical center before services are given. If you sign the notice and consent form, you can be balance billed for out-of-network services. **You are not required to sign the notice and consent form. You may seek care from an available in-network provider.**

- **Air Ambulance**
  When you receive medically necessary air ambulance services from an out-of-network provider, your cost share will be the same amount that you would pay if the service was provided by an in-network provider. Any coinsurance or deductible will be based on rates that would apply if the services were supplied by an in-network provider.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the federal No Surprises Help Desk at 1-800-985-3059.

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

If you are enrolled in the Kaiser medical plan option, contact Kaiser at the number on your ID card for information about any additional rights you may have under state law.