No Surprises Act

Effective January 1, 2022, the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts. The No Surprises Act also enables uninsured or self-pay patients to receive a good faith estimate of the cost of care.

The No Surprises Act protects consumers who get coverage through their employer (including a federal, state, or local government), through the Health Insurance Marketplace® or directly through an individual health plan, beginning January 2022, these rules will:

- Ban surprise bills for emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for all emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for supplemental care (like anesthesiology, radiology, or pathology) by out-of-network providers who work at an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining that getting care out-of-network could be more expensive and options to avoid balance bills. You're not required to sign this notice or get care out-of-network.

For consumers who don't have insurance or choose to pay for care without using insurance (also known as "self-paying" for care), these new rules make sure they can get a "good faith" estimate of how much their care will cost, before they get the care.

The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE because these programs have other protections against high medical bills.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you should not 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 have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be permitted 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, 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

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, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

In accordance with the Nebraska Out-of-Network Emergency Medical Care Act, if you receive emergency services from any health care providers, such providers are not permitted to bill you in excess of any deductible, copayment, or coinsurance amount applicable to in-network providers' emergency services pursuant to your health benefits plan. Your insurer is obligated to make sure you do not incur out-of-pocket costs greater than the out-of-pocket costs you would have incurred had you received emergency services from an in-network health care provider.

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 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

The Nebraska Out-of-Network Emergency Medical Care Act applies only to emergency services; therefore, the billing of your care involving non-emergency services is governed by federal law such as the rights and protections involving non-emergency services discussed in this notice.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Generally, your health plan 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 think you have been wrongly billed or want additional information, contact any of the following:

- The provider who sent you the bill. For bills from Pathology Medical Services PC, please contact a Customer Services Representative at (402) 465-1981.
- Your health plan
- The federal government at www.cms.gov/nosurprises/consumers or by calling the following hotline for complaints: 800-985-3059
- Visit www.cms.gov/nosurprises website for more information about your rights under federal law.
- Nebraska Department of Insurance at 402-471-2201 or toll-free consumer hotline at 877-564-7323.
- Visit www.doi.nebraska.gov for more information about your rights under Nebraska law.

Understanding costs in advance

Under the law, health care providers need to give the uninsured or those who are not using insurance an estimate of the bill for medical items and services. This is called a "good faith estimate."

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes charges for the primary item or service you're getting, and any other items or services that are provided as part of the same scheduled experience.
- For services scheduled, you are entitled to a Good Faith Estimate via email or mail before your medical service. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

If you are scheduling a procedure, your Provider will provide the estimate. If you have any questions on the pathology portion of the price estimate, please contact our Customer Services Representative at (402) 465-1981.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.