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 or it's third-party administrator (Anthem Blue Cross Blue Shield). 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.

Out-of-network cost-shares (i.e., copayments, deductibles and/or coinsurance) will apply to your claim if the treating out-of-network provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the out-of-network provider determines: (i) that you are able to travel to a network facility by non-emergency transport; (ii) the out-of-network provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the out-of-network provider after you are stabilized, you will be responsible for the out-of-network cost-shares, and the out-of-network provider will also be able to charge you any difference between the maximum allowable amount and the out-of-network provider's billed charges. This notice and consent

exception do not apply if the covered services furnished by an out-of-network provider result from unforeseen and urgent medical needs arising at the time of service.

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.

Out-of-Network Services Provided at a Network Facility

When you receive covered services from an out-of-network provider at a network facility, your claims will be paid at the out-of-network benefit level if the out-of-network provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network cost-shares for those services and the out-of-network provider can also charge you any difference between the maximum allowable amount and the out-of-network provider's billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (i) emergency services; (ii anesthesiology; (iii) pathology; (iv) radiology; (v) neonatology; (vi) diagnostic services; (vii) assistant surgeons; (viii) Hospitalists; (ix) Intensivists; and (x) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem Blue Cross Blue Shield will not apply this notice and consent process to you if Anthem Blue Cross Blue Shield does not have a network provider in your area who can perform the services you require.

Out-of-network providers satisfy the notice and consent requirement as follows: (i) by obtaining your written consent not later than 72 hours prior to the delivery of services; or (ii) if the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Anthem Blue Cross Blue Shield is required to confirm the list of network providers in its provider directory every 90 days. If you can show that you received inaccurate information from Anthem Blue Cross Blue Shield that a provider was in-network on a particular claim, then you will be liable for in-network cost shares (i.e., copayments, deductibles, and/or coinsurance) for that claim. Your network cost-shares will be calculated based upon the maximum allowed amount. In addition to your network cost-shares, the out-of-network provider can also charge

you for the difference between the maximum allowed amount and their billed charges if the out-of-network provider has complied with balance billing laws.

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 Anthem Member Services at the phone number on the back of Your Identification Card or the United States Department of Labor (USDOL).

Visit www.anthem.com for more information about your rights under federal and state laws.