On June 1, 2018, Governor Philip Murphy signed into law the "New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act".

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 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.

Summary of Key Requirements Affecting Health Care Professionals

Effective Date of Act: August 29, 2018

Entities Subject to Act:

Health Care Facilities: hospitals, ambulatory surgical centers and other licensed health care facilities.

Health Care Professionals: physicians and other licensed/certified health care professionals providing services covered under a health benefits plan.

Carriers: Insurance companies authorized to issue health benefits plans, such as health maintenance organizations and including entities such as multiple employer welfare arrangements, State Health Benefits Program and the School Employees' Health Benefits Program, but excluding certain entities/plans, such as Medicare, Medicaid, personal injury protection, workers' compensation, and those providing or administering a self-funded health benefits plan, except to the extent such self-insured plans elect to voluntarily comply with the Act's requirements (i.e., if they "opt in").

Disclosure/Notification Requirements: Health care facilities and health care professionals must disclose certain information to patients before scheduling non-emergency/elective services or procedures, such as network status and, in certain cases, the estimated fees and medical codes associated with a service.

Balance Billing Prohibition: If a patient receives at any health care facility either (1) medically necessary services on an emergency or urgent basis, or (2) "inadvertent out-of-network services," the facility and health care professional may not bill the patient for costs in excess of the patient's deductible, copayment, or coinsurance but may bill the patient's carrier for such costs.

Mandatory Assignment of Benefits: When a patient receives inadvertent out-of-network services or services on an emergency or urgent basis, the benefits provided by the patient's insurance carrier are automatically assigned to the out-of-network provider. This assignment occurs without any action on the part of the patient. Once the benefits are assigned, any reimbursement paid by the insurance carrier must be paid directly to the out-of-network provider. The insurance carrier must also provide the out-of-network provider with a written

remittance of payment specifying the proposed reimbursement and the deductible, copayment, or coinsurance amounts owed by the patient.

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 Justice - https://www.justice.gov/.

Visit www.Trinity-Rehab.com for more information about your rights under federal law.

Visit https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html for more information about your rights under state laws.