TEAMCARE®
A CENTRAL STATES HEALTH PLAN

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.

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 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	
BILLED AMOUNT:	Total amount the provider billed TeamCare for the services.
ALLOWED AMOUNT:	Benefit amount determined by Plan Section 11.09.
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.
COPAY YOU OWE:	The copay under your benefit plan (if any).
DEDUCTIBLE YOU OWE:	Amount of medical expenses that you or your covered dependents pay each calendar year before TeamCare pays certain benefits.
ELIGIBLE AMOUNT:	Amount after reduction for your *Deductible* (if any) from the *QPA*.
BENEFIT RATE:	The coinsurance percentage under your benefit plan that determines what the Plan pays for these services.
COINSURANCE YOU OWE:	The *Eligible Amount* multiplied by the Member's Coinsurance Rate.
TOTAL YOU MAY OWE:	Total of *Copay You Owe*, *Deductible You Owe, Coinsurance You Owe*, and out-of-network reduction (if any).
PLAN PAYMENT:	Is the *Allowed Amount* minus the *Total You May Owe.*

EXAMPLE
This example shows how out-of-network claims are processed and how your cost-sharing was determined.
BILLED AMOUNT:
$5,000
ALLOWED AMOUNT:
$3,500
QUALIFYING PAYMENT AMOUNT (QPA):
$3,250
COPAY YOU OWE:
$0
DEDUCTIBLE YOU OWE:
$200
ELIGIBLE AMOUNT:
$3,250 - $200 = $3,050
BENEFIT RATE:
80%
COINSURANCE YOU OWE:
$3,050 x 20% = $610
TOTAL YOU MAY OWE:
$200 + $610 = $810
PLAN PAYMENT:
$3,500 - $810 $2,690

Visit MyTeamCare.org for more information.

If there is no Qualifying Payment Amount, the No Surprises Act does not apply to those services.