

Instructions for Group Health Plans and Health Insurance Issuers
(For use for plan years beginning on or after January 1, 2022)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

- (1) the restrictions on balance billing in certain circumstances,
- (2) any applicable state law protections against balance billing,
- (3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
- (4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.¹

Plans and issuers may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review and complete it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will consider use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Language access

Use of Plain Language

Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:

- [Plainlanguage.gov/guidelines](https://www.plainlanguage.gov/guidelines)
- [Section508.gov](https://www.section508.gov)
- [LEP.gov](https://www.lep.gov)

¹ Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

Compliance with Federal Civil Rights Laws

Entities that receive federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Section 1557 and section 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Plans and issuers are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the disclosure notice provided to participants, beneficiaries, or enrollees.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 1210. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210.

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 balance 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 Blue Cross Blue Shield at 800-521-2227.