

The No Surprises Act What Montana Consumers Need to Know

March 9, 2022



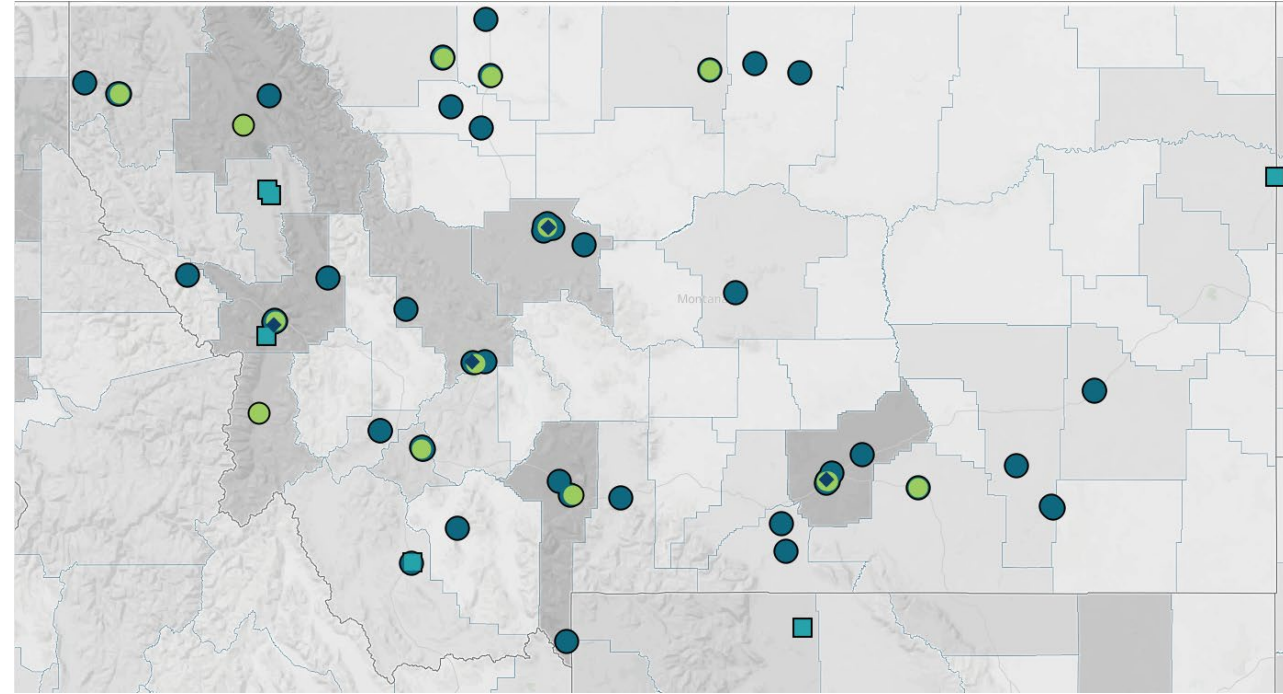
MPCA & Cover Montana

The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

The Montana Primary Care Association supports Montana's 14 Community Health Centers and five Urban Indian Health Centers. MPCA's members serve ~125,000 patients across Montana.

Cover Montana is MPCA's program focused on connecting Montanans to health insurance coverage options.



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Zoom webinar reminders

Please mute yourself, but feel free to leave your camera on, especially during Q & A!

Please rename yourself and include your pronouns and organization.

We want to know who is in our Zoom room! Please introduce yourself in the chat and let us know if there is more than one of you watching from your organization.

We are recording this webinar and the recording and resources will be posted to MPCA's Cover Montana site:

www.mtpca.org/programs/cover-montana/



Upcoming Cover Montana webinars

Wednesday, April 6th, 11am – 12:30pm

Preparing for the end of the Public Health Emergency (PHE)

[Register here](#)

Wednesday, May 11th, 11am – 12:30pm

Making sense of the health insurance appeals process

[Register here](#)

Thursday, June 9th, 11am – 12:30pm

Understanding Behavioral Health Access and Coverage

[Register here](#)



NO SURPRISES ACT

CONSUMERS NEED TO UNDERSTAND THEIR RIGHTS

A PROBLEM THAT HAS PLAGUED CONSUMERS FOR DECADES HAS FINALLY BEEN ADDRESSED

CHRISTINA LECHNER GOE, JD
MARCH 9, 2022

A LONG-STANDING PROBLEM

About one in five insured Americans who have a surgery or visit an emergency room get “balance billed.”

The Federal government estimates that:

- each year 4.1 million emergency department visits result in a hospital admission, and that 16% (or about 660,000) of these admissions will involve at least one out-of-network claim;
- 16% of 11.1 million (or about 1.8 million) in-network non-emergency facility stays for privately insured patients each year involve at least one out-of-network claim.

WHAT IS A “SURPRISE MEDICAL BILL”

Sometimes also known as a “balance billing,” which is the amount an out-of-network (OON) provider bills which is above the amount the health plan determines is the “allowable charge.”



But a surprise bill is usually unexpected.

THE NO SURPRISES ACT (NSA) BUILDS ON EXISTING ACA PROTECTIONS

- The ACA requires that “in-network” cost sharing be applied to OON emergency services but did not protect against balance billing.
- ACA limits cost sharing for consumers—maximum out-of-pocket, actuarial value (bronze, silver, gold in individual and small employer group) and minimum actuarial value provisions (large employer group)-- but **ONLY** if the services are provided **in-network**.

The NSA vastly improves these protections by removing the threat of “balance billing” from many common scenarios.



HOW the NSA PROTECTS CONSUMERS FROM BALANCE BILLING

If the NSA applies to a claim, the OON provider must first contact the health plan to determine what the patient's in-network cost sharing is and then may only bill the patient for that amount.

Any dispute about the "qualified payment amount" is between the provider and the health plan. The consumer is not affected. Any coinsurance amount is based on the QPA as predetermined by the plan.

The consumer has the right to file complaints about potential NSA violations or even seek an external appeal.



THE NSA APPLIES TO THESE TYPES OF HEALTH PLANS

Commercially insured individual and employer group health insurance coverage (including grandfathered health plans)

“Self-funded” employer group health plans

Federal employee health plans AND nonfederal government health plans

Student health plans

The NSA does not apply to short term limited duration health plans, excepted benefits, HRA's, or retiree only plans.

It also does not apply to Medicaid, CHIP, or Medicare because those plans are already protected.

THE NSA PROTECTS AGAINST BALANCE BILLING IN THESE SITUATIONS

EMERGENCY CARE provided at an in-network (IN) or OON facility

- Includes hospital emergency departments (EDs) and independent free-standing EDs and urgent care centers licensed to provide ER services
- POST STABILIZATION SERVICES, regardless of where in the hospital they are provided (unless patient can be safely transported).

NON-EMERGENCY CARE at an in-network facility by an OON provider

- Includes hospitals, hospital out-patient department, critical access hospitals and ambulatory surgical centers. Includes single case agreements
- Extends to entire visit: devices, imaging, labs, and services from ancillary physicians

AIR AMBULANCE SERVICES

- includes helicopters, fixed wing, and inter facility transport
- **does not apply to ground ambulance services**

Statement of Account

Date	For	Description	Ref	Patient	Insurance
11/24/2020	██████	INSURANCE ADJUSTMENT 111620 2	176864		-1974.89
11/24/2020	██████	Not covered by insurance	176864	887.11	-887.11
11/05/2020	██████	IOL MASTER OD OS OU	177016		165.00
11/25/2020	██████	PRIMARY INSURANCE PYT 50.46 DEDUCTIBLE	177016		
11/25/2020	██████	INSURANCE ADJUSTMENT 112320 D	177016		-114.54
11/25/2020	██████	Not covered by insurance	177016	50.46	-50.46
11/05/2020	██████	PREMIUM LENS	177022	640.00	
11/05/2020	██████	PATIENT PYT CREDIT CARD 510577	177022	-640.00	
11/05/2020	██████	POST-OP EXAM	177085		
					Balances Due
					Patient Insurance
0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	120 Days Past Due	
\$1318.05	\$0.00	\$0.00	\$0.00	\$0.00	\$1318.05 \$0.00

Notes

PAYMENTS RECEIVED AFTER 12/01/20 WILL BE ON YOUR NEXT STATEMENT.

PLEASE CALL 406-455-2020 IF YOU HAVE ANY QUESTIONS.

THANK YOU!

Statement of Account

Date	For	Description	Ref	Patient	Insurance
11/03/2020	██████	COMPREHENSIVE	176804		251.00
11/24/2020	██████	PRIMARY INSURANCE PYT 238.96 DEDUCTIBLE	176804		
11/24/2020	██████	INSURANCE ADJUSTMENT 111620 2	176804		-12.04
11/03/2020	██████	IOL MASTER OD OS OU	176804		165.00
11/24/2020	██████	PRIMARY INSURANCE PYT 141.52 DEDUCTIBLE	176804		
11/24/2020	██████	INSURANCE ADJUSTMENT 111620 2	176804		-23.48
11/24/2020	██████	Not covered by insurance	176804	380.48	-380.48
11/03/2020	██████	CATARACT	176864		2862.00
11/24/2020	██████	PRIMARY INSURANCE PYT 887.11 DEDUCTIBLE	176864		
					Balances Due
					Patient Insurance
0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	120 Days Past Due	

Notes

PAYMENTS RECEIVED AFTER 12/01/20 WILL BE ON YOUR NEXT STATEMENT.

PLEASE CALL 406-455-2020 IF YOU HAVE ANY QUESTIONS.

THANK YOU!

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL



Forwarding Service Requested

J737 9-817

Patient Name: [REDACTED] Member ID: [REDACTED]
 Claim Number: [REDACTED] Provider Name: [REDACTED] Patient Acct #: [REDACTED]

Date of Service	Services Provided	Amount Billed	Discount	Reason Code	Paid Provider	Paid You	Deductible Amount	Copy Amount	Coinsurance Amount	Amount You Owe
11/05/20	6698454 - Surgery	\$2,862.00	\$1,974.89	U04 PSV	\$0.00	\$0.00	\$887.11	\$0.00	\$0.00	\$887.11
Claims Totals:		\$2,862.00	\$1,974.89		\$0.00	\$0.00	\$887.11	\$0.00	\$0.00	\$887.11

Amount You Owe: \$887.11

Patient Name: [REDACTED] Member ID: [REDACTED]
 Claim Number: [REDACTED] Provider Name: Helena Surgicenter LLC Patient Acct #: [REDACTED]

Date of Service	Services Provided	Amount Billed	Discount	Reason Code	Paid Provider	Paid You	Deductible Amount	Copy Amount	Coinsurance Amount	Amount You Owe
11/03/20	669845G - Surgery	\$3,091.00	\$309.10	PDC 606	\$0.00	\$0.00	\$2,781.90	\$0.00	\$0.00	\$2,781.90
Claims Totals:		\$3,091.00	\$309.10		\$0.00	\$0.00	\$2,781.90	\$0.00	\$0.00	\$2,781.90

Amount You Owe: \$2,781.90

Patient Name: [REDACTED] Member ID: [REDACTED]
 Claim Number: [REDACTED] Provider Name: [REDACTED] Patient Acct #: [REDACTED]

Date of Service	Services Provided	Amount Billed	Discount	Reason Code	Paid Provider	Paid You	Deductible Amount	Copy Amount	Coinsurance Amount	Amount You Owe
11/03/20	00142QZ - Anesthesia	\$600.00	\$273.48	PXJ	\$0.00	\$0.00	\$326.52	\$0.00	\$0.00	\$326.52
Claims Totals:		\$600.00	\$273.48		\$0.00	\$0.00	\$326.52	\$0.00	\$0.00	\$326.52

Amount You Owe: \$326.52

Patient Name: [REDACTED] Member ID: [REDACTED]
 Claim Number: [REDACTED] Provider Name: St. Peters Hospital Patient Acct #: [REDACTED]

Date of Service	Services Provided	Amount Billed	Discount	Reason Code	Paid Provider	Paid You	Deductible Amount	Copy Amount	Coinsurance Amount	Amount You Owe
11/12/20	0300 - Lab	\$18.72	\$1.87	PDC	\$0.00	\$0.00	\$16.85	\$0.00	\$0.00	\$16.85
11/12/20	0301 - Lab	\$84.94	\$8.49	PDC	\$0.00	\$0.00	\$76.45	\$0.00	\$0.00	\$76.45
Claims Totals:		\$103.66	\$10.36		\$0.00	\$0.00	\$93.30	\$0.00	\$0.00	\$93.30

Amount You Owe: \$93.30

Accumulator Totals
 Accumulator totals are based on the last claim processed. View your most current information on [REDACTED]

	Family Member	Plan Year	Member Year to Date	Member Maximum	Family Year to Date	Family Maximum
In-Network Provider Deductible	[REDACTED]	01/01/2020	6400.54	6750.00	6670.98	13500.00
Out-of-Network Provider Deductible	[REDACTED]	01/01/2020	0.00	13500.00	0.00	27000.00
OOP Individual/Family In-network	[REDACTED]	01/01/2020	6400.54	6750.00	6670.98	13500.00

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL



In

J820 9-879

Subscriber:
 Subscriber ID:
 Group Name:
 Group Number:

Hi [REDACTED]

Don't worry, this isn't a bill.
 This is a customized Explanation of Benefits based on your insurance claims.

This document gives you information about how an insurance claim from a health provider (such as a doctor, hospital, or pharmacy) was paid on your behalf. Please review this document and keep for your records.

For updates to your account, please log into [REDACTED] or call our Customer Service team.

Information on the appeal process is provided in the following pages of this document.
 Your health is important to us. Please let us know how we can help!

Here's a summary of claims for the period of: 10/30/2020 thru 11/18/2020

Total Billed Amount **\$13,603.72** This is the total amount of charges for claims received with dates of service of 10/30/2020 thru 11/18/2020.

Amount Paid to Provider **\$2,442.88** This is the total amount the Plan paid on claims received with dates of service 10/30/2020 thru 11/18/2020.

Amount Paid to You **\$0.00** This is what is paid to you.

Total Coinsurance **\$0.00** A percentage of covered expenses you pay after you meet your deductible.

Total Deductible **\$5,938.46** The portion of submitted charges applied towards your deductible. Your deductible is the amount you need to pay each year before your plan starts paying certain benefits. Please refer to your Benefit Summary for services subject to your deductible.

Total Copay **\$0.00** A flat fee you pay for certain covered services such as doctor visits or prescriptions.

Total Auto-Recovered **\$0.00** The amount withheld from your payment due to prior overpayments.

You Saved **\$7,665.26** This is a total of your discount and what your plan paid.

Explanation of Benefits Details

This is not a bill. It's a statement showing how we processed your claim.

Claim Totals

Amount billed	\$39.77
Discount	\$0.00
Amount we paid your provider(s)	\$25.46
Amount you may owe	\$14.31

Subscriber ID:	[REDACTED]
Group:	[REDACTED]

Claim Details

Claim Date 02/08/2022

Claim Number	224066313800	Patient Provider	[REDACTED] Pharmacy	Member ID	[REDACTED]	Patient Acct.	[REDACTED]			
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$1.67	\$0.00	\$1.67	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Claim Totals	\$1.67	\$0.00	\$1.67	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Claim Totals

Claim Date 02/08/2022

Claim Number	224066314900	Patient Provider	[REDACTED] Pharmacy	Member ID	[REDACTED]	Patient Acct.	[REDACTED]			
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$1.73	\$0.00	\$1.73	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Claim Totals	\$1.73	\$0.00	\$1.73	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Claim Details

Claim Date 02/08/2022

Claim Number	224066317800	Patient Provider	[REDACTED] Pharmacy	Member ID	[REDACTED]	Patient Acct.	[REDACTED]			
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$6.43	\$0.00	\$0.00	\$0.00		\$6.43	\$0.00	\$0.00	\$0.00	\$6.43
Claim Totals	\$6.43	\$0.00	\$0.00	\$0.00		\$6.43	\$0.00	\$0.00	\$0.00	\$6.43

Claim Details

Claim Date 02/08/2022

Claim Number	224066321600	Patient Provider	[REDACTED] Pharmacy	Member ID	[REDACTED]	Patient Acct.	[REDACTED]			
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$6.43	\$0.00	\$0.00	\$0.00		\$6.43	\$0.00	\$0.00	\$0.00	\$6.43
Claim Totals	\$6.43	\$0.00	\$0.00	\$0.00		\$6.43	\$0.00	\$0.00	\$0.00	\$6.43

Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$14.36	\$0.00	\$14.36	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Claim Totals	\$14.36	\$0.00	\$14.36	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Claim Date 02/08/2022

Claim Number	224066322500	Patient Provider	Christina L. Goe Pharmacy	Member ID	200524747-01	Patient Acct.	000000001361553			
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$7.88	\$0.00	\$0.00	\$0.00		\$7.88	\$0.00	\$0.00	\$0.00	\$7.88
Claim Totals	\$7.88	\$0.00	\$0.00	\$0.00		\$7.88	\$0.00	\$0.00	\$0.00	\$7.88

Claim Date 02/08/2022

Claim Number	224066327800	Patient Provider	Christina L. Goe Pharmacy	Member ID	200524747-01	Patient Acct.	000000001361551			
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Prescriptions	\$7.70	\$0.00	\$7.70	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Claim Totals	\$7.70	\$0.00	\$7.70	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Claim Date 02/08/2022

Deductible and Out-of-Pocket Summary

Plan Year 01/01/2022

Individual

Christina	OOP Individual/Family Out-of-network	\$0.00 Met	\$14,000.00 Remaining
Claim Totals			

	OOP Individual/Family In-network	\$14.31 Met	\$6,985.69 Remaining
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	Out-of-Network Provider Deductible	\$0.00 Met	\$14,000.00 Remaining
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	In-Network Provider Deductible	\$14.31 Met	\$6,985.69 Remaining
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Family

	OOP Individual/Family Out-of-network	\$0.00 Met	\$28,000.00 Remaining
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Individual

Christina	OOP Individual/Family In-network	\$33.94 Met	\$13,966.06 Remaining
	Out-of-Network Provider	\$0.00 Met	\$14,000.00 Remaining

Surprise Medical Bills: Your Rights and Protections

You are protected against surprise billing and balance billing when you get emergency care or you are treated by an out-of-network provider at an in-network hospital or other medical facility.

Surprise billing is an unexpected balance bill. This can happen when you cannot control who is involved in your care (for example, when you have an emergency, or when you schedule a procedure at an in-network facility but are unexpectedly treated by an out-of-network provider).

Balance billing is when an out-of-network provider bills you for the difference between the full amount charged for a service and your plan's allowed amount for the service.

Balance billing protections: If you get emergency services from an out-of-network provider or facility, you cannot be balance billed for these 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 balance billed for these poststabilization services).

When you get services from an in-network hospital or ambulatory surgical center, some of their 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, and intensivist services. These providers can't balance bill you, and may not ask you to give up your protections not to be balance billed.

You are responsible only for the share of costs such as copayments, coinsurance, or deductibles you would pay if the provider or facility were in-network. Note that your health plan will pay out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring prior authorization from the health plan;
- Cover emergency services by out-of-network providers;
- Base what you owe the provider or facility (your cost share amount) on what it would pay an in-network provider or facility, and show that amount in your explanation of benefits; and
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

You cannot be compelled or required to give up your surprise or balance billing protections. You are not required to get care from out-of-network providers. You can choose a provider or facility in your plan's network.

If you believe you've been wrongly billed, you may contact:

Montana Consumer Assistance Program
840 Helena Ave
Helena, MT 59601
Tel: **(800) 332-6148**
Web: <https://www.csi.mt.gov>

For more information about your rights under federal law, visit www.CMS.gov/nosurprises/consumers.

Customer Advocates are here to help! 1-800-820-1674

Amount Billed	\$130.00
Discounts and Reductions	- \$24.87
Health Plan Responsibility	- \$80.13
You may owe your health care provider for these services	\$25.00

YOUR BENEFITS APPLIED

YOUR RESPONSIBILITY

Service Description	Service Dates	YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				Your Total Costs
		Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	
Medical Visits	08/18/2021	130.00	(1)24.87	105.13	80.13		25.00			25.00
CLAIM TOTALS		\$130.00	\$24.87	\$105.13	\$80.13	\$0.00	\$25.00	\$0.00	\$0.00	\$25.00

Total covered benefits approved for this claim: \$80.13 to [redacted] on 08-25-21.

Notes about amounts under “YOUR BENEFITS APPLIED” and “YOUR RESPONSIBILITY”

(1) The amount billed is more than what is allowed for this service. Your provider should not bill you for any balance over what is allowed.

Benefits are being paid at the higher level since you used a contracting provider in the PPO network.

[redacted] Benefit Period: 07-01-21 Through 06-29-22 To date this patient has met \$50.00 of her/his \$4,000.00 Out-of-pocket Expense.

Benefit Period: 07-01-21 Through 06-29-22 To date \$50.00 of the family \$8,000.00 Out-of-pocket Expense has been met.

Customer Advocates are here to help! 1-800-820-1674

Amount Billed	\$243.00
Discounts and Reductions	- \$40.71
Health Plan Responsibility	-\$202.29
You may owe your health care provider for these services	\$0.00

Service Description	Service Dates	YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				Your Total Costs
		Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	
Medical Visits	11/22/2021	183.00	(1)32.02	150.98	150.98					0.00
Laboratory Services	11/22/2021	60.00	(1)8.69	51.31	51.31					0.00
CLAIM TOTALS		\$243.00	\$40.71	\$202.29	\$202.29	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Total covered benefits approved for this claim: \$202.29 to COST CARE WALK IN CLINIC on 12-09-21 .

Notes about amounts under “YOUR BENEFITS APPLIED” and “YOUR RESPONSIBILITY”

(1) The amount billed is more than what is allowed for this service. Your provider should not bill you for any balance over what is allowed.

er on the

Amount Billed	\$415.00
Discounts and Reductions	-\$128.53
Health Plan Responsibility	-\$125.20
You may owe your health care provider for these services	\$161.27

Service Description	Service Dates	YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				Your Total Costs
		Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	
Medical Visits	05/17/2021	210.00	(1)59.80	150.20	125.20		25.00			25.00
X-Ray Services	05/17/2021	70.00	(1)15.76	54.24		54.24				54.24
X-Ray Services	05/17/2021	70.00	(1)15.76	54.24		54.24				54.24
Med/Surg Supplies	05/17/2021	65.00	(1)37.21	27.79		27.79				27.79
CLAIM TOTALS		\$415.00	\$128.53	\$286.47	\$125.20	\$136.27	\$25.00	\$0.00	\$0.00	\$161.27

Total covered benefits approved for this claim: \$125.20 to MISSOULA BONE & JOINT on 06-09-21.

Notes about amounts under “YOUR BENEFITS APPLIED” and “YOUR RESPONSIBILITY”

(1) The amount billed is more than what is allowed for this service. Your provider should not bill you for any balance over what is allowed.

Benefits are being paid at the higher level since you used a contracting provider in the PPO network.

TREY W HILL - Benefit Period: 07-01-20 Through 06-30-21 To date this patient has met \$136.27 of her/his \$750.00 Health Care Plan Deductible. To date this patient has met \$411.27 of her/his \$4,000.00 Out-of-pocket Expense.

Benefit Period: 07-01-20 Through 06-30-21 To date \$136.27 of your family Health Care Plan Deductible has been met. To date \$786.27 of the family \$8,000.00 Out-of-pocket Expense has been met.

above address is incorrect or has changed. Please indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.
PLEASE INCLUDE YOUR ACCOUNT # ON YOUR CHECK.

Date	Description		Charges	Payments & Adjustments	Patient Responsibility
	TREY W HILL (172630) / DOUGLAS HENRY PA/977203				
	Location: MBJ CLINIC				
05/17/2021	NEW PT INTERMEDIATE OFFICE VISIT	99203	210.00		
05/17/2021	X-ray, shoulder, 2, 3 or 4 views	73030	70.00		
05/17/2021	X-ray, shoulder, 2, 3 or 4 views	73030	70.00		
05/17/2021	Band-It	A4467	65.00		
06/14/2021	BLUE CROSS Adjustment from BLUE CROSS			-128.53	
06/14/2021	BLUE CROSS Payment from BLUE CROSS			-125.20	
		BALANCE :			161.27



PAYMENT IN FULL IS DUE UPON RECEIPT OF THIS STATEMENT. To pay your balance by credit or debit card, call 704-412-7213 extension 7213. To make your payment online, please visit our website.



Forwarding Service Requested

J186

24,182

Explanation of Benefits

What is this? This is not a bill. It's a statement showing how we processed your claim

Claim Totals

Amount Billed	\$335.00
PacificSource discount	\$108.56
Amount we paid your provider(s)	\$0.00
Amount you may owe	\$226.44

Subscriber

Group

Questions? We're here to help.

Take charge of your EOBs Get more detail or go paperless:

Claim Details

Claim Date 02/01/2022

Claim Number

Patient

Member ID

Provider

Patient Acct.

Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
99214 - Medical Service	\$335.00	\$108.56	\$0.00	\$0.00	798	\$226.44	\$0.00	\$0.00	\$0.00	\$226.44
Claims Totals:	\$335.00	\$108.56	\$0.00	\$0.00		\$226.44	\$0.00	\$0.00	\$0.00	\$226.44

Reason Code Explanations

Code

Description

798 SmartHealth Network Allowance

Explanation of Benefits Details

This is not a bill. It's a statement showing how we processed your claim.

Claim Totals	03/06/2022
Amount billed	\$294.05
PacificSource discount	\$245.36
Amount we paid your provider(s)	\$48.69
Amount you may owe	\$0.00
Subscriber	[REDACTED]
Group	[REDACTED]

Claim Details

Claim Date 02/23/2022

Claim Number	Patient	[REDACTED]	Member ID	[REDACTED]						
[REDACTED]	Provider	Quest Diagnostics	Patient Acct.	[REDACTED]						
Services Provided	Amount Billed	Discount	We Paid Provider	We Paid You	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Auto-Recovered	Amount You May Owe
Lab 85025	\$45.50	\$34.31	\$11.19	\$0.00	PXN ⓘ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Lab 36415	\$22.50	\$19.50	\$3.00	\$0.00	PXN ⓘ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Lab 80053	\$88.07	\$72.86	\$15.21	\$0.00	PXN ⓘ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Lab 80061	\$137.98	\$118.69	\$19.29	\$0.00	PXN ⓘ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Claim Totals	\$294.05	\$245.36	\$48.69	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

WHAT ARE ANCILLARY PHYSICIANS?

INCLUDES:

- Anesthesiologists, radiologists, assistant surgeons, emergency room providers, pathologists, neonatologists, hospitalists, intensivists, and most laboratory services.

These providers supply necessary services but are not necessarily chosen by the patient.

- For example: the patient chooses an in-network hospital, and an in-network physician or surgeon, but these ancillary services may also be necessary, foreseen (anesthesiology) or unforeseen (pathologist). The patient does not have the opportunity to choose, and the provider may be OON.



IMPORTANT DEFINITION CLARIFICATIONS FOR EMERGENCY SERVICES AND POST STABILIZATION SERVICES

Clarifies/reiterates that health plans cannot deny emergency care

- without first applying a prudent layperson standard—whether a prudent person would reasonably seek emergency care based on their symptoms;
- Based solely on diagnostic codes; or
- Because of a time limit based on onset of symptoms or because symptoms were not sudden.

Emergency services includes post stabilization services until the patient can be safely transported to an in-network facility, no matter where in the hospital such services are furnished, including outpatient observation and in-patient or outpatient stay;

- “Safely transported” means transported by nonmedical/nonemergency means to an available (accepting patients) in-network hospital within a reasonable distance, and the patient gives consent.



OBLIGATIONS OF HEALTH PLANS IF THE NSA APPLIES

- Must determine the Qualified Payment Amount (QPA) for every type of service in advance.
 - The QPA is the **median** of the health plan's contracted rates for the same or similar item or service in a geographic area for the same type of insurance product.
- May not bill the OON cost sharing, even if an OON provider is accessed.
- Must negotiate with the OON provider if they dispute the QPA. The consumer is out of it.
- If the arbitrator decides that an amount higher than the QPA is owed to the OON provider, the health plan bears that cost, not the consumer.



OBLIGATIONS OF HEALTHCARE PROVIDERS IF THE NSA APPLIES TO A CLAIM

The OON provider can only bill the patient their in-network cost sharing amount, as specified by the patient's health plan. He/she must communicate with the health plan to determine the appropriate amount before sending a bill to the patient.

- If coinsurance applies, the coinsurance amount is based on the qualifying payment amount (QPA) that the health plan has predetermined for that particular service.
- The OON can dispute the amount of the QPA, BUT the patient is not involved in those disputes—the OON provider and the payer must resolve the dispute between themselves.



RESOLVING DISPUTES BETWEEN OON PROVIDERS AND HEALTH PLANS

If the OON provider wishes to dispute the QPA, they have 30 days to negotiate with the health plan.

In Montana, if negotiations fail, the parties can access a federal independent dispute resolution (IDR) process.

- Some other states have a state-specific process.

Each party submits their best offer, and an arbitrator (HHS certified) must select one amount or the other.

- Arbitrator may only consider certain information: the QPA, provider's training and experience, acuity/complexity of patient's condition, previous good faith efforts to enter into a network agreement--
 - barred from considering billed charges, UCR, or Medicare/Medicaid rates.
- Administrative fees will apply.




CONSENT TO WAIVE NSA PROTECTIONS

PATIENTS MAY KNOWINGLY AND VOLUNTARILY AGREE TO BE BALANCE-BILLED BY OON PROVIDER BUT ONLY FOR:

- Non-emergency care
 - *Example:* patients knowingly chooses an OON orthopedic surgeon because they believe they will have a better outcome and they also have the funds to pay out of pocket
- Post-stabilization services, if the patient can be safely transported by nonmedical or nonemergency means to an in-network facility within a reasonable distance

NSA PROTECTIONS CANNOT BE WAIVED:

- When there is no in-network provider available
- For urgent or unforeseen care
- Post stabilization care where the patient cannot be safely transported
- Services from ancillary provider services that the patient does not normally select--emergency medicine, anesthesiology, radiology, pathology, neonatology, hospitalists, intensivists, assistant surgeons, and labs




REQUIREMENTS FOR WRITTEN WAIVER AND CONSENT REQUIREMENTS

Must be in writing and fully inform patient (or authorized representative) of the consequences of waiving NSA rights (HIGHER COSTS)

Providers and facilities must use the standard written notice and consent created by HHS, and it must:

- Be “filled in” by the provider;
- Provide a good-faith cost estimate of the charges, with separate services broken out, including any prior authorization or care management requirements;
- Specify that consent is not required, and in-network care can be requested. A list of in-network providers must be provided;
- Be provided separately from other documents, 72 hours in advance (3 hours if same day) and name specific providers;
- Be signed by patient or authorized representative.

CONSUMERS SHOULD CAREFULLY READ THE “SURPRISE BILLING PROTECTION FORM” BEFORE SIGNING.



HEALTH PLANS
MUST EDUCATE
THEIR MEMBERS
REGARDING THEIR
NSA RIGHTS

Deliver or post on their website a consumer-friendly document explaining NSA protections and rights

Repeat those rights on every explanation of benefit (EOB), with instructions on where to get more information and how to file a complaint

Providers, facilities, and air ambulance companies must also provide disclosures



ENFORCEMENT

States are the primary enforcers of the NSA, if willing and able. More “protective” state law will control over the minimum federal protections.

- Approximately 35 states have some protections already existing
- Montana does not
- Montana CSI has agreed to seek “voluntary compliance” from health insurers that it regulates.
- If compliance does not occur, the matter will be referred to the appropriate federal agency.
- No Montana state enforcement for provider compliance

Consumer and provider education is critical to implementing the consumer protections in this new law and to making this law work.

COMPLAINTS ARE THE KEY TO EFFECTIVE ENFORCEMENT.




FILE A COMPLAINT!

If a health plan appears to be out of compliance and if the plan is “fully insured” by a health insurance company, file a complaint/inquiry with CSI and they will investigate.

- All provider, facility and air ambulance complaints, must go directly to HHS.

HHS has established one system for all consumer complaints that will direct the complaint to the correct agency (USDOL, state DOI, CMS, etc.) for a seamless experience.

Before filing a complaint, a consumer should first call the provider and the health plan and seek a correction/explanation.

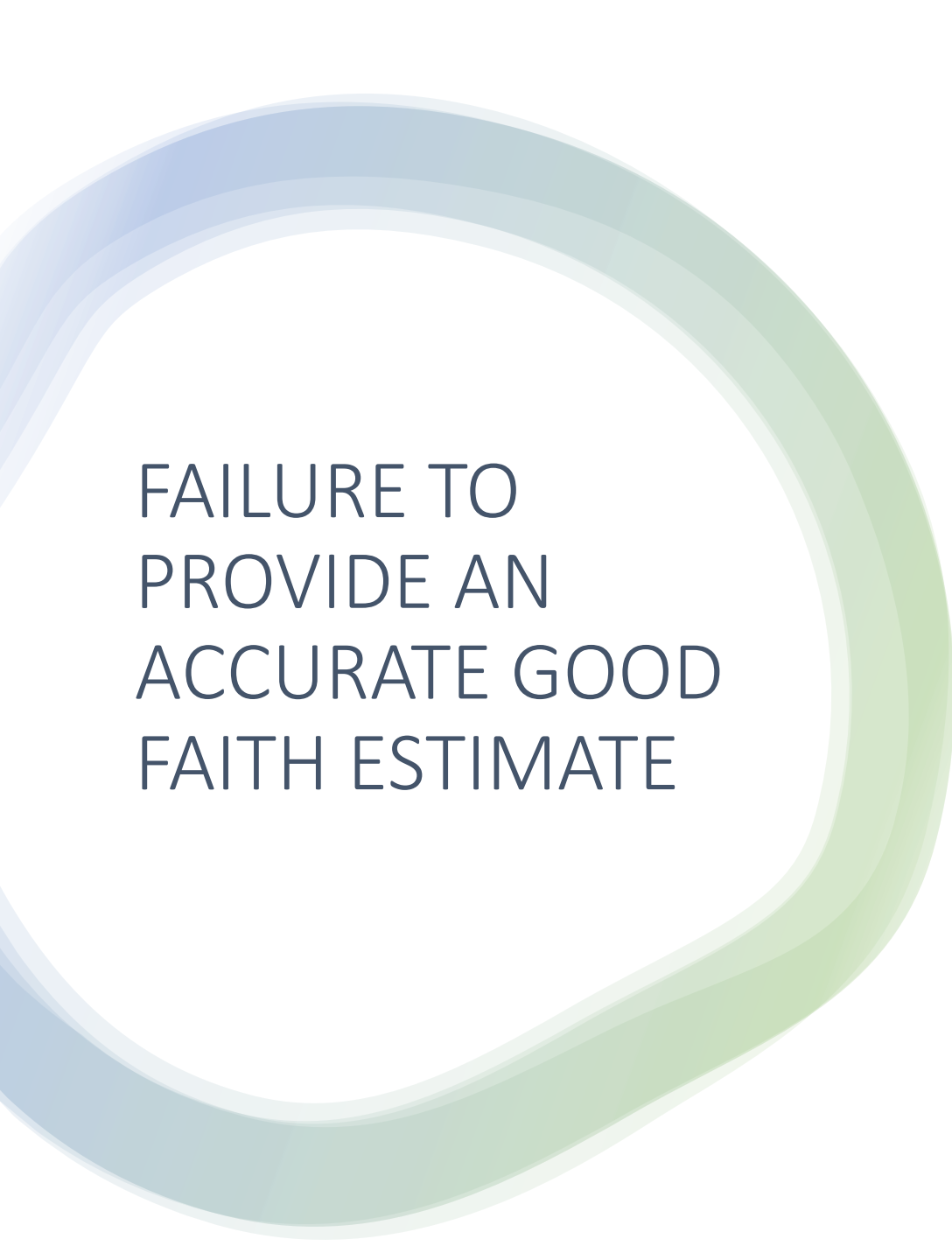


OTHER CONSUMER PROTECTION PROVISIONS OF THE NSA

- UNINSURED AND SELF PAY PATIENTS -

GOOD FAITH ESTIMATES

- Even if the ban on balance billing does not apply, the NSA requires that all providers and facilities (including FQHCs) provide a good faith estimate of the total charges to uninsured or self-pay patients. Self-pay is an individual that has coverage but does not intend to use it.
- Good faith estimates are required for insured patients as well.
 - The provider must provide the plan with an estimate of charges and the plans must provide an advance EOB (delayed enforcement).
- A good-faith estimate must be the “true” estimated charges, including the cash payment rate, any discounts or adjustments (financial assistance).
- Must be provided when health care services are scheduled or when the information is requested and must be in writing, on paper or electronic.
- These estimates do not apply to Medicare or Medicaid.
- The “convening” provider or facility must coordinate the estimates on behalf of co-providers and co-facilities (delayed enforcement).



FAILURE TO PROVIDE AN ACCURATE GOOD FAITH ESTIMATE

- If the billed charges substantially exceed the good faith estimate (by \$400 or more), the uninsured/self-pay patient may dispute the charge through the patient/provider dispute resolution process established by HHS.
- The Consumer Financial Protection Bureau (CFPB) has issued a new bulletin emphasizing the need for debt collectors and credit bureaus to comply with the NSA when collecting or reporting medical debt.
 - *Example:* they may not collect or report a medical debt that is a balance bill that violates the NSA.

EXPECTED IMPACT OF NO SURPRISES ACT

Impact on health costs

- CBO estimates that lower provider payments will reduce premium by 0.5 – 1.0 %, resulting in about \$17 billion in federal savings over 10 years.

Impact on provider networks—unknown?

- Will the new system encourage certain types of providers to join networks in order to avoid administrative complexity?
- Will greater transparency about OON providers make consumers more aware of the importance of using in-network providers?

Will good faith estimates make consumers more proactive about seeking both quality AND lower costs? Will they also, make them more aware of their ability to bear the cost of “cheaper” health plans with higher costs sharing?



MORE INFORMATION

CONSUMER EDUCATION DOCUMENT

<https://uspirg.org/sites/pirg/files/reports/US%20PIRG%20Surprise%20Medical%20Bills%20Patient%20Protections%20Tips.pdf>

FILE A COMPLAINT

MONTANA OFFICE OF THE COMMISSIONER OF SECURITIES AND INSURANCE (FOR FULLY INSURED PLANS): 1-800-332-6148; www.csi.mt.gov

HHS CENTRALIZED COMPLAINT SYSTEM:

1-800-985-3059

www.cms.gov/nosurprises