For Citi's Medical Plans Administered by Aetna, Anthem, Select Health and HMSA

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network health care professional at an in-network hospital or ambulatory surgical center, you are protected from surprise or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see any in-network health care professional, you may be required to pay certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. If you receive health care services out-of-network, you may be required to pay additional costs to those noted above.

"Out-of-network" describes providers and facilities that have not signed a contract to charge a negotiated rate with your health plan for a service. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay in the contract and the full amount it otherwise charges for a service. This is called "**balance billing**." The balance billed amount is more than you are required to pay for the in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise or balance billing" is an unexpected bill that you may receive for health care services that are provided by an out-of-network health care professional or facility that exceed the in-network costs. This can happen when you cannot control who is involved in your care—like when you need emergency care or when you schedule an appointment at an in-network facility but are unexpectedly treated by an out-of-network health care professional.

You are protected from surprise or balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network health care professional or facility, the most you may be billed is your plan's in-network cost-sharing amount (such as deductible, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you knowingly 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 health care professionals working in the facility may be out-of-network, not subject to the negotiated in-network contract rate structure. 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 **cannot** 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 **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also aren't required to get care out-of-network under the circumstances noted above. If you otherwise choose an out-of-network doctor or facility, you can be balanced billed.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (copays, coinsurance and deductibles that you would pay if the provider or facility were 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 have been wrongly balance billed, you may contact U.S. Department of Health and Human Services at 1-800-985-3059.

Visit No Surprises Act | CMS for more information about your rights under federal law.

For Citi's Medical Plan Administered by Kaiser Permanente

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network health care professionals at an in-network hospital or ambulatory surgical center, you are protected from surprise or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see any in-network health care professional, you may be required to pay certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. If you receive health care services out-of-network, you may be required to pay additional costs to those noted above.

"Out-of-network" describes providers and facilities that have not signed a contract to charge a negotiated rate with your health plan for a service. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay in the contract and the full amount it otherwise charges for a service. This is called "**balance billing**." The balance billed amount is more than you are required to pay for the in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise or balance billing" is an unexpected bill that you may receive for health care services that are provided by an out-of-network health care professional or facility that exceed the in-network costs. This can happen when you cannot control who is involved in your care—like when you need emergency care or when you schedule an appointment at an in-network facility but are unexpectedly treated by an out-of-network health care professional.

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 you may be billed 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 are in stable condition, unless you knowingly give written consent and give up your protections not to be balanced billed for these post-stabilization services.

When a member must receive emergency care from out-of-network providers, Kaiser will calculate the member cost-sharing based on the recognized amount, which is based on the All-Payer Model Agreement, the specified state law, or the qualifying payment amount (QPA) for emergency services or the lesser of the QPA or billed charges for air ambulance services. Upon

receiving a claim, Kaiser will pay the provider an out-of-network rate less the member cost-sharing.

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 health care professionals working in the facility may be out-of-network, not subject to the negotiated in-network contract rate structure. 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 **cannot** 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 **cannot** balance bill you, unless you give written consent and give up your protections.

You are <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network under the circumstances noted above. If you otherwise choose an out-of-network doctor or facility, you can be balanced billed.

Kaiser Permanente is actively working to implement the regulations and requirements that relate to surprise billing protections for certain non-emergency services provided by an out-of-network provider at an in-network facility.

<u>When balance billing is not allowed, you also have the following protections:</u>

- You are only responsible for paying your share of the cost (copays, coinsurance and deductibles that you would pay if the provider or facility were 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 have been wrongly balance billed, you may contact Member Services at 1-800-464-4000; 1-800-788-0616 (Spanish); 711 TTY 24/7 for most services, except major holidays.