

No Surprises Act

Frequently Asked Questions

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FAQs for Consumers:

What are surprise or balance bills?

Surprise bills, or balance bills, may occur when patients visit an out-of-network provider or facility. For example, if the facility bills \$100 for a service and Sanford Health Plan normally pays \$75 for the service, the facility can bill the member for the difference (\$25) between the billed and reimbursed amounts. These bills, especially if for an emergency or air ambulance service, can be extremely expensive and unexpected. The No Surprises Act protects consumers against such types of surprise billing for certain services.

What services are protected under the No Surprises Act?

- Emergency services used to examine, treat or stabilize members, including hospitalization and associated services, such as radiology, labs and inpatient providers that the member may not be able to choose in an emergent situation and/or admission.
- Air ambulance services
- Out-of-network providers who provide services located within an in-network facility. (Example: The member goes to an in-network hospital, but an out-of-network doctor performs their colonoscopy).

Who is protected under the No Surprises Act?

Consumers who get coverage through their employer (including a federal, state or local government), through the Health Insurance Marketplace® or directly through an individual health plan are protected under the No Surprises Act.

Does the law apply if I choose to use an out-of-network provider?

No. The No Surprises Act doesn't impact claims related to members who choose to use out-of-network providers. If a member chooses to receive out-of-network care, the provider and/or facility must provide them with a plain-language consumer notice explaining that patient consent is required to get care on an out-of-network basis before that provider can bill the consumer. By signing this notice, the member is giving up important consumer protections and balance billing may continue with those claims.

What types of medical bills does the No Surprises Act prohibit?

- The law bans surprise billing for emergency services, even if they're provided out-of-network. These services will be covered at an in-network rate without requiring prior authorization from your insurance company.
- The law bans balance billing and out-of-network cost-sharing (like out-of-network coinsurance or copayments) for emergency and certain non-emergency services. In these situations, the consumer's cost for the service cannot be higher than if these services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.
- The law bans out-of-network charges and balance billing for ancillary care (for example, labs, radiology reading, anesthesia, assistant surgeon, etc.) by out-of-network providers at an in-network facility. For example, if you have bloodwork done at your in-network clinic with your in-network provider but your tests are sent to an out-of-network lab, you must be billed at in-network rates. Another example is if you undergo surgery at an in-network hospital with an in-network surgeon but receive anesthesia from an out-of-network anesthesiologist, you can't be balance billed for that service.
- The law bans certain other out-of-network charges and balance billing without advance notice. If you choose to receive out-of-network care, the provider and/or facility must provide you with a plain-language consumer notice explaining that patient consent is required to get care on an out-of-network basis before that provider can bill the consumer. By signing this notice, you are giving up important consumer protections.

NOTE: You are **never** required to give up your protections from balance billing. You are also not required to get care out-of-network. Look for providers and facilities in your plan's network.

What should a member do if they signed a waiver giving up balance billing consumer protections but now regret it?

They can cancel a waiver within five business days of signing by contacting the facility or provider directly. They can also cancel the scheduled service or visit to avoid being charged for it.

How do members find in-network providers and facilities?

View the provider directory to find care near you by visiting sanfordhealthplan.com/members. Click "Find a Provider or Pharmacy." You can also contact us at the number on the back of your ID card.

Does the No Surprises Act protect consumers enrolled in Medicare or Medicaid?

No, the No Surprises Act does not cover those enrolled in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE because those programs have other protections for consumers against costly medical bills.

Can members view an estimate of costs before visiting their provider?

Yes. Providers and facilities are required to give consumers cost estimates ahead of a service as well as potential out-of-network costs. Members can contact Sanford Health Plan to request an estimate as well, however, specific information will be required from their provider to provide an accurate estimate.

Does the No Surprises Act require changes to my insurance ID card?

Yes. Impacted members will receive a new ID card that includes the following information: in-network and out-of-network deductibles, out-of-pocket maximum limit, phone number and website where individuals can seek consumer assistance.

What should members do if they believe they have been wrongfully billed?

Members can call Sanford Health Plan Customer Service at (888) 234-2042. We can help to determine if members have been wrongfully billed. They may also contact the CMS No Surprises Help Desk at (800) 985-3059.

Minnesota residents may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 for more information about their rights under Minnesota law.

What is the arbitration or mediation process, and do I need to participate in it?

Consumers do not participate in arbitration. Arbitration, or Independent Dispute Resolution (IDR), will take place if an insurer and provider are unable to negotiate an agreed-upon rate for a service covered under the No Surprises Act during the 30-day Open Negotiation Period.

What are the additional price transparency requirements for the state of South Dakota?

The State of South Dakota passed a law that requires South Dakota-based health plans to display pharmacy information on our website. The files are in machine-readable file format and will be updated monthly. Files for individual, small group and commercial plans can be found under "Rx Drug Price Transparency" at sanfordhealthplan.com/no-surprises-act.

FAQs for Providers:

How do providers submit information for the provider directory?

Sanford Health Plan has partnered with Quest Analytics to maintain an updated provider directory. Every 90 days, Quest will contact providers to verify the details we have in our provider directory. Once the details are sent back and verified, Sanford Health Plan will update provider directories within two business days.

How will Quest contact providers?

Quest will contact providers via email and fax, so provider offices are encouraged to keep their contact information up to date by emailing providerrelations@sanfordhealth.org

What happens if a provider's data cannot be verified?

If providers do not respond to the verification request or their information cannot be verified, the provider will be removed from the online provider directory. Once the information is verified, the provider will be added back to the directory within two business days.

Will the unverified provider be removed from the Sanford Health Plan network?

No, the provider will remain in our network but will not show up on our online provider directory until their information is able to be verified.

How soon must the provider directory be updated once the provider returns verified information?

Two business days

What is the Independent Dispute Resolution (arbitration) process?

The No Surprises Act allows for a 30-day Open Negotiation Period for providers and payers to settle out-of-network claims. If the parties cannot reach an agreement within the allotted time, Independent Dispute Resolution can begin. One party begins arbitration by submitting a notification to the U.S. Department of Health and Human Services.

Each party will submit a final offer along with supporting documentation. The Independent Dispute Resolution will determine which offer is most reasonable. The arbitration decision is final, and the losing party must pay the cost of the arbitration process.

What is the Open Negotiation Period?

A 30-day Open Negotiation Period will begin when the claimant submits forms to Sanford Health Plan disputing a surprise bill. During the Open Negotiation Period, Sanford Health Plan and the provider or facility requesting payment will work to find a mutually agreeable negotiated rate. If the Open Negotiation Period is unsuccessful after 30 days, Sanford Health Plan or the provider or facility may initiate the Independent Dispute Resolution process.

Is there a minimum monetary threshold requirement to request dispute resolution?

No

Can claims be batched when requesting dispute resolution?

Claims that are related to the original out-of-network covered items and services that were furnished by the same provider within a 30-day period may be combined for purposes of dispute resolution.

Does the federal No Surprises Act preempt state surprise billing laws?

The law may not preempt state surprise billing laws that establish a process for determining out-of-network reimbursement for covered items and services for insurers subject to the state's law.

What are the requirements of the No Surprises Act for providers, facilities and air ambulance providers?

CMS has provided a high-level summary [HERE](#).