CITY OF SPARKS
2022 ANNUAL GROUP HEALTH PLAN NOTICES

Important: Please read the Plan Notices listed below.

- Children's Health Insurance Program (CHIP)
- General Notice of COBRA Rights
- Special Enrollment Rights
- The Women's Health and Cancer Rights Act
- Notice of Privacy Practices
- Employer Exchange Notice
- No Surprises Act

Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healhcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**. If you live in Nevada, you may be eligible for assistance in paying your employer health plan premiums. Contact the **Nevada Medicaid at 1-800-992-0900,** http://dwss.nv.gov for more information on eligibility. **To see if any other states have added a premium assistance program or for more information on special enrollment rights, contact either:**

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

General Notice of COBRA Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact Human Resources at 775-353-2345.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (such as Silver State Health Insurance Exchange). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to our Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to Human Resources.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to

Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage:** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

- **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may extend their COBRA continuation coverage, for a maximum of 36 months (as measured from the first qualifying event), if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions
Questions concerning your Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator to:

City of Sparks Human Resources
431 Prater Way
Sparks, Nevada 89431
775-353-2345

Shorter Maximum for Health FSAs
The maximum federal COBRA period for a health flexible spending arrangement (health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event) ends on the last day of the plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in our Plan under "special enrollment provisions" briefly described below.

- **Loss of Other Coverage**. If you decline enrollment for yourself or eligible dependents because you have other group health coverage or other health insurance, you may be able to enroll yourself and your dependents under the health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 31 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.

- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption**. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under our health plan. You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.

- **Enrollment Due to Medicaid/CHIP Events**. If you or your eligible dependents are not already enrolled in our health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included in the CHIP Model Notice.

Please contact the Human Resources at 775-353-2345 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

The Women's Health and Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan. If you would like more information on WHCRA benefits, call the Human Resources at 775-353-2345.

Notice of Privacy Practices

City of Sparks Human Resources **431 Prater Way, Sparks, NV 89431**	**Privacy Officer Contact Information: 775-353-2345** **e-mail: hr@cityofsparks.us**

Your Information, Your Rights, Our Responsibilities
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

- **Get a copy of your health and claims records.** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.

- **Correct your health and claims records**. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

- **Request confidential communications**. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

- **Ask us to limit the information we share**. You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- **Get a list of those with whom we've shared your information**. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Get a copy of this privacy notice**. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- **Choose someone to act for you**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you believe your privacy rights have been violated**. You can complain if you feel we have violated your rights by contacting our Privacy Officer.

You may file a complaint with the U.S. Department of Health & Human Services for Civil Rights by sending a letter to:

200 Independence Avenue SW, Washington D.C. 20201
Call 877-696-6775 or visit www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

- **Help manage the health care treatment you receive.** We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

- **Run our organization.** We can use and disclose your information to run our organization and contact you when necessary. **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans. Example: We use health information about you to develop better services for you.
- **Pay for your health services.** We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.
- **Administer your plan.** We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

- **Help with public health and safety issues.** We can share health information about you for situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

- **Do research.** We can use or share your information for health research.

- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director.** We can share health information about you with organ procurement organizations. We can also share health information with a coroner, medical examiner, or funeral director when an individual dies.

- **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Additional Restrictions on Use and Disclosure
Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS
2. Mental health
3. Genetic tests
4. Alcohol and drug abuse
5. Sexually transmitted diseases and reproductive health information
6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document summarizing additional restrictions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Health Insurance Marketplace Coverage

General Information

In 2014, key parts of the health care law provided a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace typically begins in October.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at 775-353-2345.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

No Surprises Act 2022

The No Surprises Act, a new law included within the Consolidated Appropriations Act, 2021, effective January 1, 2022, addresses, among other things, a prohibition on surprise billing (also known as balance billing), which impacts emergency room parity rules previously implemented under the Affordable Care Act ("ACA") and ACA provisions related to provider choice. Additionally, §2719A of the PHSA requires emergency services to be provided:

A. Without prior authorization (whether they are provided by an in-network or out-of-network provider),

B. Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; and,

C. Without imposing administrative requirements or limitations on the coverage that are more restrictive than those that apply to in-network providers when emergency services are provided out-of-network.

Among other things, the No Surprises Act sunsets §2719A of the ACA effective January 1, 2022 and replaces it with new emergency services requirements for group health plans (under §2799A-1 and 2799A-2 of the PHSA), and recodifies the provider choice provisions (under §2799A-7 of the PHSA). Further, the No Surprises Act extends the recodified provider choice requirements and the new emergency care provisions to all group health plans, among other plans, except those plans consisting of excepted benefits. Thus, all nonexcepted group health plans – fully-insured, self-funded, grandfathered, and non-grandfathered must comply with these requirements.

The new emergency services requirements protect individuals from surprise medical bills by requiring all non-excepted group health plans and issuers that cover hospital emergency room services or emergency services provided in a freestanding, independent emergency department, to cover services without imposing any prior authorization or limitation on coverage regardless of whether the provider is a participating provider or emergency facility.

Essentially, all emergency services must be covered in the same manner regardless of whether they are provided by an in-network or out-of-network provider or facility. Further, any participant cost sharing requirements for out-of-network emergency services providers or facilities must be the same as cost-sharing requirements for in-network emergency services providers or facilities and must be counted towards any applicable in-network deductible or OOP maximums under the plan.

Similarly, the No Surprises Act requires group health plans and issuers to cover nonemergency services provided by out-of-network providers working at in-network facilities, as well as air ambulance services provided by out-of-network providers, using the same general approach as emergency services described above.

As described above, balance billing is prohibited in many situations, such as for emergency services and certain ancillary services connected to non-emergency care at in-network facilities, such as anesthesiology services or radiology services provided by out-of-network providers contracted by the in-network facility.

In other non-emergency situations balance billing may be permitted if the non-participating facility or provider meets certain, stringent advance notice and consent requirements under §2799A-2(d) of the PHSA. For the notice, the provider must provide participants, beneficiaries, or enrollees a written or electronic notice at least 72 hours before the appointment (or the date the appointment is made if it is less than 72 hours before the appointment), containing the following information:

That the provider or facility is non-participating/OON under the plan;

A. A good faith estimate of charges for the items or services needed/involved, including that the estimate or consent does not constitute a contract with respect to the charges estimated for the items or services provided;

B. If the facility is in-network, but the provider providing services at the facility is not, then a list of any participating providers at the facility who are able to furnish the necessary items or services, and that the participant can be referred, at their option, to a participating provider; and

C. Whether prior authorization or other care management limits are required before a participant can receive items or services from the non-participating provider.

The notice must clearly state that consent to receive items or services from a nonparticipating provider is optional, and that the participant can seek treatment or care from a participating provider or facility instead that would have more favorable cost sharing.

The notice must be available in the 15 most common languages in the geographic region of the applicable facility or provider. The consent must be written in clear, understandable language, and indicate that the participant, beneficiary or enrollee has been:

A. Provided with the above written notice in the form selected by the participant (written or electronic).

B. Informed that payments made towards the service or item may not accrue towards meeting any cost sharing limitations under their medical coverage, including that it may not apply towards the in-network deductible under the plan, if any.

C. The consent form must include the date the participant, enrollee, or beneficiary received the notice, and the date they signed the consent. A signed copy of the consent must be provided to the participant, beneficiary, or enrollee.

The No Surprises Act instructed the DOL, IRS, and HHS to develop rules by July 1, 2021, that include the methodology the group health plan can use to determine the qualifying payment amount, information the group health plan must share with the nonparticipating provider or facility, geographic regions, and a process to receive complaints of violations. The Interim Final Rule fulfills that requirement.

Among other things, the Interim Final Rule defines "emergency medical condition" and "emergency services" similar to how those terms are defined under the Emergency Medical Treatment and Labor Act ("EMTALA"); however, the definition of "emergency services" includes pre-stabilization services provided after a patient is moved out of the emergency department and admitted to a hospital such that these services are protected under the No Surprises Act. "Emergency services" also include certain post-stabilization services. Further, according to the preamble to the regulations, defining "emergency medical condition" consistent with EMTALA ensures that group health plans or issuers must cover emergency services without limiting what constitutes an emergency medical condition solely based on diagnosis codes.

The Interim Final Rules specify the methodologies that group health plans can use to determine cost-sharing amounts for (1) out-of-network emergency facilities, (2) out-of-network emergency providers, and (3) certain non-emergency services furnished by out-of-network providers at certain in-network facilities. Specifically, the Interim final Rules require that cost sharing amount be calculated by using:

A. An amount determined by an applicable All-Payer Model Agreement under §1115A of the Social Security Act.

B. If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.

C. If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan's or issuer's median contracted rate.

The regulations provide guidance for determining the median contracted rate. Cost sharing amounts for out-of-network air ambulance services must be calculated using the lesser of the billed charge or the plan's or issuer's qualifying payment amount, and the requirement must be the same as if services were provided by an in-network air ambulance provider. Rates for out-of-network providers (including any cost sharing) must be based on:

A. An amount determined by an applicable All-Payer Model Agreement under §1115A of the Social Security Act.

B. If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law.

C. If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.

If none of the three conditions above apply, an amount determined by an independent dispute resolution entity. Regulations related to the independent dispute resolution process and entities have not been issued; however, the agencies indicated that they intend to release the regulations soon.

Additionally, certain health care providers and facilities, as well as health plans and health issuers are required to make a notice publicly available, post on a website (for health plans, that would be a website of the plan), and provide individuals a notice about:

A. The restrictions on balance billing in certain circumstances,

B. Any applicable state law protections against balance billing, and

C. 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

Health plans and issuers are also required include the above information on each EOB containing an item or service for which the No Surprises Act applies. The agencies released a model notice for health plans and issuers.