WHAT IS A SURPRISE BILL?

A surprise bill may happen when you receive care from a provider who is not in your plan's network — and you didn't know or couldn't reasonably avoid it. The No Surprises Act (NSA) protects you from these bills in the following situations:

1. Emergency services at an out-of-network hospital or free-standing facility
2. Services from out-of-network providers working at in-network/participating facilities
3. Air ambulance services from out-of-network providers

Balance billing Is not allowed

Providers are not allowed to bill you for the difference between what they charge and what your plan pays (called "balance billing") in these cases. This includes:

- Emergency medicine
- Anesthesiology
- Pathology
- Radiology
- Neonatology
- Laboratory and diagnostic services
- Services from assistant surgeons, hospitalists, and intensivists

Even if there's no in-network/participating provider available, you're still protected.

No waivers allowed

You cannot be asked to waive these protections for:

- Emergency services
- Urgent medical needs that arise unexpectedly
- Ancillary services (like those listed above)
- Diagnostic tests
- Services from out-of-network providers when no in-network/participating option is available

SECTION XI – ADDITIONAL HEALTH BENEFITS PROGRAM PROVISIONS

SECTION 1. PLAN CONSTRUCTION. The health plans offered through the New York City Health Benefits Program shall be construed, enforced, and administered, and the validity thereof determined in accordance with the laws of the State of New York, to the extent not preempted by Federal law.

Masculine pronouns used in this Summary Program Description shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply. Any headings or subheadings in this Summary Program Description are inserted for convenience of reference only and shall be ignored in the construction of any provisions of the Summary Program Description.

SECTION 2. NON-ALIENATION AND ASSIGNMENT. The health plans offered through the New York City Health Benefits Program shall not be liable for any debt, liability, contract, or tort of any Employee or Covered Person. The health plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and, except as provided under a qualified medical child support order, no health plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided, however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician, or other service provider provided, further, that any such assignment of benefits by a Covered Person to a Hospital, Physician, or other service provider shall be binding on the health plan only if:

1. The Plan Administrator is notified of such assignment prior to payment of benefits;

2. The assignment is made on a form provided by, or approved by, the Plan Administrator; and

3. The assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator.

SECTION 3. FAILURE TO ENFORCE. Failure to enforce any provisions of this Summary Program Description does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

SECTION 4. QUALIFIED MEDICAL CHILD SUPPORT ORDERS. The health plans offered through the New York City Health Benefits Program shall provide benefits in accordance with the applicable requirements of a qualified medical child support order received by the Plan Administrator. If the Plan Administrator receives a medical child support order, the Plan Administrator shall promptly notify the Covered Person, and each child of the Covered Person identified in the order, of the receipt of such order and the applicable health plan's procedures for determining whether the order is a qualified medical child support order. Within a reasonable time after receipt of such order, the Plan Administrator shall determine whether the order is a qualified medical child support order and notify the Covered Person and each child involved of the determination. The Plan Administrator shall establish written procedures to determine whether a medical child support order received by the Plan is a qualified medical child support.

SECTION 5. LIMITATION OF RIGHTS AND OBLIGATIONS. Neither the establishment nor maintenance of a health plan offered through the New York City Health Benefits Program nor any amendment thereof, nor any act or omission under the applicable health plan or resulting from the operation of the applicable health plan shall be construed:

A. As conferring upon any Covered Person, beneficiary or any other person a right or claim against the City of New York or the Plan Administrator, except to the extent that such right or claim shall be specifically expressed and provided in this Summary Program Description, or applicable health plan summary plan documents or provided under applicable law;

B. As creating any responsibility or liability of the City of New York or Plan Administrator for the validity or effect of a health plan offered through the New York City Health Benefits Program;

SECTION 6. NOTICES. Any notice given under a health plan offered through the New York City Health Benefits Program shall be sufficient if given to the Plan Administrator, when addressed to it at its office at New York City Employee Benefits Program, 22 Cortlandt Street, 12th Floor, New York, NY 10007; or if given to a Covered Person, when addressed to the Covered Person at his or her address as it appears on the records of the Plan Administrator.

SECTION 7. RECEIPT AND RELEASE. Any payments to any Covered Person shall, to the extent thereof, be in full satisfaction of the claim of such Covered Person being paid thereby and the health plan, the Plan Administrator, or an Employer may condition payment thereof on the delivery by the Covered Person of the duly executed receipt and release in such form as may be determined by the Plan, the Plan Administrator, or an Employer

SECTION 8. MISREPRESENTATION. Any material misrepresentation on the part of the Covered Person in making application for coverage, or reclassification of coverage, or in applying for and/or obtaining benefits under a health offered through the New York City Health Benefits Program, shall render the coverage null and void.

SECTION 9. ENTIRE PLAN. This New York City Health Benefits Summary Program Description and applicable certificates of coverage/summary plan descriptions for health plans offered through the New York City Health Benefits Program shall constitute the only legally governing documents for the New York City Health Benefits Program. All statements made by the City of New York, Plan Administrator, or Benefit Administrator shall be deemed representations and not warranties. No such statement shall void or reduce coverage under the a health plan offered through the New York City Health Benefits Program or be used in defense to a claim unless in writing signed by the Plan Administrator or its designee. In the event that there may be a discrepancy between any other communication provided to Covered Persons regarding this New York City Health Benefits Summary Program Description Plan document and applicable summary plan descriptions for health plans offered through the New York City Health Benefits Program, the New York City Health Benefits Summary Program Description Plan document and applicable summary plan descriptions for health plans offered through the New York City Health Benefits Program will prevail.

SECTION 10. FACILITY OF PAYMENT. Whenever a Covered Person to whom payments are directed to be made shall be mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the City of New York, the Plan Administrator, the Benefits Administrator, nor any fiduciary of the New York City Health Benefits Program shall be under any obligation to see that a legal representative is appointed. Notwithstanding, the Plan Administrator, or its designee, may, in its sole

discretion, make a payment under a health offered through the New York City Health Benefits Program directly to a health care provider or to the guardian or conservator, or the parents of a minor child, or to an individual or individuals who have custody or provide care and principal support to the Covered Person. In addition, in the event of the Covered Person's death, payment may be made, in the Plan Administrator's sole discretion, to the duly qualified and acting personal representative of that Covered Person's estate (or, if there is no such personal representative, to the person or persons entitled to such payments). A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Administrator or any fiduciary shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

SECTION XII – SUMMARY OF HEALTH PLANS

A "non-grandfathered health plan" must comply with certain consumer protections under the Affordable Care Act and cover certain in-network preventive services with $0 co-payments to the enrolled participants, such as those listed below:

– Routine physicals
– Immunizations
– Colonoscopies
– Mammograms
– Birth control prescriptions and other preventive prescriptions

For a complete list of preventive services and medications, please contact the applicable health plan.

Effective July 1, 2020, the Blue Access Anthem Gated EPO offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective July 1, 2017, the HIP HMO Plan offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective July 1, 2016, the GHI-Comprehensive Benefits Program/Anthem Blue Cross Blue Shield Plan (GHI-CBP) offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective July 1, 2016, the DC 37 Med-Team offered to DC 37 City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective January 1, 2016, the MetroPlus Gold plan offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

The City of New York believes that all of the other health plans currently, as of July 2017, offered as health benefits coverage to City employees through the City of New York Health Benefits Program are “grandfathered health plans” under the Affordable Care Act.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed, in writing only, to:

City of New York Health Benefits Program
22 Cortlandt Street, 12th Floor
New York, NY 10007
Attention: Grandfathered Plan Status

You may also contact the U.S. Department of Health and Human Services at www.HHS.gov

CHOOSING A HEALTH PLAN

Contact the health plans in which you are interested for benefits packages and provider directories. Telephone numbers, addresses and Websites are listed at the beginning of each plan description. To select a health plan that best meets your needs, you should consider at least four factors:

Coverage - The services covered by the plans differ. For example, some provide preventive services while others do not cover them at all; some plans cover routine podiatric (foot) care, while others do not.

Choice of Doctor - Some plans provide partial reimbursement when non-participating providers are used. Other plans only pay for, or allow the use of, participating providers.

Convenience of Access - Certain plans may have participating providers or centers that are more convenient to your home or workplace. You should consider the location of physicians' offices and hospital affiliations.

Cost - There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a payroll deduction. Additional benefits (e.g., prescription drug coverage) may be available through an Optional Rider. These costs are compared on the rates charts which are available on the Health Benefits Program Website at nyc.gov/hbp. Some plans require copayments for certain services. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services. The plan you have chosen will send you information regarding your health benefits coverage when you enroll.