No Surprises Act

Sections 102, 104, & 105

What is the No Surprises Act?	
The No Surprises Act (NSA) establishes new protections and industry guidance against surprise medical bills and other services, beginning on or after January 1, 2022. The following provisions are currently effective:	
Surprise Medical Bills	Also known as balance bills, arise when care is received by an out-of-network (OON) provider (hospital, doctors, etc.), when emergent or out-of-control (ground ambulance transportation does not apply).
The No Surprises Act — Sections 102 & 104: Applicable Services	Any emergent service or services rendered by an OON provider which are performed at an in-network (IN) facility (such as an anesthesiologist or attending physician) will not be subject to surprise billing. These services will be covered at the IN cost-sharing and apply toward any applicable IN deductible and out-of-pocket maximum. Example situation: You schedule a routine colonoscopy at an IN facility. For the procedure, you see an OON anesthesiologist. The anesthesiologist cannot balance bill the difference between billed-charges and the plan/member cost-sharing. **See the below exception to this rule**
Are OON Providers Still Permitted to Balance Bill?	Yes! Providers must give members advanced notice that services are OON and obtain consent. If the member gives consent, the OON provider may balance bill. Services will be covered at the OON cost-sharing and apply toward any applicable OON deductible and out-of-pocket maximum. The advance notice must include an estimate of charges at least 72 hours prior to services (if non-emergent) or immediately upon notice of a service. Using the Example Situation from above: If the OON anesthesiologist provided you with advanced notice and you provided consent, you could be subject to balance billing. Consent should accompany the claim and a copy should be kept for your records. If you decline, the colonoscopy may be cancelled or delayed until an IN anesthesiologist can be scheduled.
Air Ambulance	
The No Surprises Act — Section 105: Air Ambulance Services	Members are held harmless from surprise air ambulance bills and will only be required to pay the IN cost-sharing. Providers are barred from balance billing. Advanced notice and consent will not apply.

No Surprises Act

Section 113: Continuity of Care

<table>
<tr><th colspan="2">What is Continuity of Care?</th></tr>
<tr><td colspan="2">Continuity of care occurs when a member is undergoing treatment for a serious or complex condition (for example, cancer, pregnancy, terminal illness, scheduled non-elective surgery) and their provider is no longer in-network (IN). This can occur if:

• the provider terminates with the plan’s current network; or
• the plan begins accessing a new provider network</td></tr>
<tr><td>How Long Can A Member Continue to Receive Care?</td><td>The member may continue to utilize services through their (now) out-of-network (OON) provider for up to 90 days. The 90-day clock starts upon the “event” date — either provider termination or new plan effective date when member’s network changes.

Claims should continue to be processed as IN.</td></tr>
<tr><td>What Happens After the 90 Days?</td><td>The member will need to find a new IN provider.

After 90 days, if the member choses to see the OON provider, the member will be responsible for the OON cost-sharing and may be balance billed the difference.</td></tr>
<tr><td>How to Notify Nova of a Potential Continuity of Care Situation</td><td>A Continuity of Care Form (found in the Knowledge Center: Member Resources tab on www.novahealthcare.com) must be completed by you and your provider, to identify a potential Continuity of Care situation. Once both pages are completed, the form should be sent to Nova for review, as indicated on the bottom of the form.</td></tr>
<tr><td>What if the Member Has Not Been Seen Recently?</td><td>If the member moves from one network to another and hasn’t visited their (now) OON provider within 90 days, those visits will be processed as OON, the plan’s applicable OON cost-sharing will apply, and the member may be balance-billed.</td></tr>
</table>

Questions: If you have any questions or if you believe you are receiving care for a serious or complex condition and your provider is now considered OON, please email UMRequests@novahealthcare.com with the subject “No Surprises Act Continuity of Care” or call Nova’s Customer Service number on your ID card.

No Surprises Act Continuity of Care Form

Please clearly PRINT all information

Options to return this two-page form
Mail: Nova Healthcare Administrators
PO Box 1543, Buffalo, NY 14231
Fax: (716) 250-7170, Attn: Medical Management
Email: UMRequests@novahealthcare.com,
Subject: No Surprises Act Continuity of Care

THIS SECTION TO BE COMPLETED BY MEMBER

1	Name:	Member ID number:	Date of birth:
2	Address:	City:	State/ZIP:
3	Home phone:	Cell phone:	Work phone:
4	Employer name:	Employer plan enrollment:	
5	Member's relationship to employee: ___ Self ___ Spouse ___ Dependent ___ Other	Is the member currently covered by other health insurance carrier? _____ Yes _____ No If yes, carrier name:	
6	Previous health insurance company and plan name:	Date coverage ended:	Was previous health plan still offered? _____Yes _____ No
Medical condition for which you are completing this application: (complete one form for each condition/provider)			
7	_____ I am pregnant or am receiving post-partum care. _____ I am receiving outpatient care on a long-term basis for conditions such as, but not limited to, cancer or dialysis. _____ I am receiving home care or hospice services. _____ I am seeing a physician regularly (once per month) to actively manage a condition that is not stable. _____ I am a transplant candidate or recipient in need of ongoing care due to complications associated with the transplant. _____ I have an upcoming (non-elective) surgery scheduled and authorized. _____ I am being treated inpatient (hospital, skilled nursing, or rehabilitation facility). _____ I have durable medical equipment (DME) in the home (such as oxygen, wheelchair, etc.) paid for by my medical plan. _____ Other		
8	Condition, services, or treatment receiving, or type of DME:		
9	Physician, surgeon, or OB/GYN	Name:	Address: Phone:
10	Hospital, agency, facility, or DME supplier	Name:	Address: Phone:
11	Date of surgery, transplant, admission, or delivery (if applicable):		

Member certification and authorization to release records:
I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I authorize all physicians and other health care professionals, facilities, or medical service providers to provide Nova Healthcare Administrators, Inc., or its agents or employees, all information concerning medical care, advice, treatment or supplies for the member names above. This information will be used to determine the member's eligibility for the No Surprises Act - Continuity of Care benefits under the plan.

I also authorize Nova Healthcare Administrators, Inc. to leave confidential information on my voicemail at the number(s) listed above.
Please indicate all that apply: _____Home _____Cell _____Work _____Do NOT leave confidential information on my voicemail.

Printed name of person responding:	
Member's signature/parent or guardian's signature if member is a minor:	Date of signature:

Continuity of Care/Transition of Care Application

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER

12	Name:	National Provider Identifier (NPI) or TIN:	Phone:
13	Address:	City:	State/ZIP:
14	Hospital name:		Hospital phone number:
15	Date of last appointment:	Date of next appointment:	Frequency of visits:
16	Diagnosis:	Expected length of treatment:	If maternity: Expected date of delivery:
17	Is the treatment for an exacerbation of a previous injury or chronic condition? _____ Yes _____ No Does the member have a terminal condition? _____ Yes _____ No ICD-10:		
18	Current treatments and comments (include all relevant CPT codes) associated with condition on this application: Please attach: Initial consult report from the treating provider(s), current treatment plan, and last three progress notes.		
19	What is the current in-network rate you receive for these services?		

The above-named patient is a Nova Healthcare Administrators, Inc. member. We understand you are not, or soon will not be, a participating provider under the member's Network. The member has asked that for a defined period of time, we treat claims for the condition defined on Page 1 as In-Network under the member's benefit plan for the covered services you provide as a non-participating provider. This is because of a qualifying condition. If we approve this request, you agree (1) to provide the covered service for the defined period of time, including any follow-up care covered under the member's plan, and (2) if applicable, the terms and condition of your participation will continue to apply to the covered service, including any follow-up care covered under the member's plan. Please note the following:

- If applicable, payment under your participation agreement, together with any copayment or deductible for which the member is responsible under the plan, is payment in full for the covered service and you will not seek to recover, and will not accept any payment from, the member, Nova Healthcare Administrators, Inc., or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge.
- Upon request and approval of the patient, you will share information regarding the member's treatment with Nova Healthcare Administrators, Inc.
- If applicable, you will make referrals for services including laboratory services to network providers in accordance with the terms of your participation agreement. For any questions on providers within network, please contact Provider Services on your patient's ID card.

Signature of Health Care Professional:	Date of signature:

Return this 2-page form through one of the following:

Mail	Email	Fax
Nova Healthcare Administrators, Inc. Attn: Medical Management Department PO Box 1543 Buffalo NY 14231	UMRequests@novahealthcare.com Subject: No Surprises Act Continuity of Care Application	716-250-7170 Attn: Medical Management Department

CONFIDENTIALITY NOTICE:
This information you have received may contain protected and privileged, highly confidential medical information, Personal and Health Information (PHI), and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you have received this information in error, please notify the sender immediately and confidentially destroy the information that was sent in error.