LAPRA

2024 Legally Required Notices

Each year there are legally required notices and disclosures that LAPRA is required to make available to participants in LAPRA's benefit plans. These notices and disclosures are for your information.

Notice or Disclosure

Required Notifications and Other Important Information

Section 125 Important Announcement for Active Members

Please Read Carefully

The medical and dental plans provided by LAPRA to active members are subject to Section 125 of the Internal Revenue Code. As provided under Section 125, once you make a benefit election for you and, if applicable, your family, you will generally not be able to change your election until the next annual open enrollment period. Except in the limited situations described below, the benefits you choose must remain in effect throughout the plan year (July 1 – June 30).

Once you elect to enroll in or decline coverage for you, your spouse, or dependent, you may only change that election according to the following rules:

- You may add a new spouse or dependent to your coverage only if:
  - You become legally married. (See note on page 2 regarding domestic partners.)
  - You acquire a newly eligible dependent. If you enroll in a medical plan a new dependent that you acquired through birth, adoption, or placement for adoption, and your spouse is eligible but not enrolled for coverage in that plan, you may also enroll your spouse in that plan.
  - There is a court order directing that a dependent be added to your coverage.
  - You are called to or return from active duty in the uniformed services.

- You may drop a spouse or dependent from your coverage only if:
  - You become divorced or legally separated, your marriage is annulled, or your spouse dies.
  - You lose a dependent.
  - Your spouse or dependent moves, and due to the move, your spouse or dependent is no longer eligible for coverage under your plan.
  - There is a court order directing that a dependent be removed from your coverage.
  - You are called to or return from active duty in the uniformed services.

- If you are not enrolled in a LAPRA plan, you may enroll for coverage only if:
  - You return from an unpaid leave of absence.
  - You also enroll for coverage a newly eligible dependent that you have acquired through marriage, birth, adoption, or placement for adoption.
  - You had declined coverage because you were covered under another plan (including federal COBRA continuation coverage) and you lose eligibility for coverage under that plan (or in the case of federal COBRA coverage, you exhaust such coverage).
  - You are called to or return from active duty in the uniformed services.

- If you are enrolled in a LAPRA plan, you may drop that coverage only if:
  - You move, and due to the move, you are no longer eligible for coverage under your plan.
  - You are on an unpaid leave of absence.
  - You are called to or return from active duty in the uniformed services.

- If you are enrolled in a LAPRA plan, you may change plans only if:
  - All of the following apply: (i) you, your spouse, or your dependent moves, (ii) due to the move, you, your spouse, or your dependent is no longer eligible for coverage under the plan you were enrolled in, and (iii) coverage for you, your spouse, or your dependent is available under the plan in which you wish to enroll.
  - You are called to or return from active duty in the uniformed services.
  - You are adding a new dependent to your coverage.

- If your spouse or dependent is not enrolled in a LAPRA plan, you may add them to your coverage only if:
  - You had declined coverage for your spouse or dependent because your spouse or dependent was covered under another plan (including federal COBRA continuation coverage) and your spouse or dependent loses eligibility for coverage under that plan (or in the case of federal COBRA coverage, your spouse or dependent exhaust such coverage).
  - In certain very limited circumstances, if your coverage under the LAPRA plan you have selected is reduced (for example, there is a significant increase in your deductible), you may be allowed to elect coverage in another plan available through LAPRA. In addition, in certain very limited circumstances, if you experience a complete loss of coverage under a LAPRA plan (for example, an HMO is no longer available where you live), you may be allowed to elect coverage under another LAPRA plan or drop coverage entirely.
  - You are called to or return from active duty in the uniformed services.

Domestic Partners: Domestic partners may also be enrolled for coverage according to the applicable plan procedures. The enrollment of domestic partners who are not otherwise your dependent, however, is not governed by Section 125.

Submission of Enrollment for Election Change: Any request to change your election according to the rules set forth above must be made within 31 days after the event for which a change in election is permitted. The change in election will generally be effective the first day of the month following receipt of the enrollment form by LAPRA. **If your request is not received within 31 days, you must wait until the next enrollment period.**

If you have questions about the circumstances under which you may change your benefit elections, please send an email to **benefits@lapra.org** or call our office at 213-674-3701.

Notice Regarding Summary of Benefits and Coverage (SBC)

The plans offered by LAPRA offer a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, LAPRA makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at **www.lapra.org/tools.html**. A paper copy is also available, free of charge, by sending an email to **benefits@lapra.org** or calling LAPRA at 213-674-3701.

Los Angeles Police Relief Association, Inc. Health Plan Notice of Privacy Practices

The Los Angeles Police Relief Association, Inc. Health Plan Notice of Privacy Practices is available online at **www.lapra.org/privacy.html**. You may also request a copy by sending an email to **benefits@lapra.org** or calling LAPRA at 213-674-3701.

Submission of Enrollment for Election Change

Any request to change your election must be made within 31 days after the event for which a change in election is permitted. The change in election will generally be effective the first day of the month following the event. **If your request is not received within 31 days, you must wait until the next enrollment period.**

Active Members and Non-Medicare-Eligible Retirees: You will make any election changes online at **www.LAPRALive.org**.

Medical-Eligible Retirees: Access **www.LAPRALive.org** to view your current benefits and update your personal information, information about your covered dependents and beneficiary designations. To enroll or make changes to your benefits, contact a LAPRA Benefits Representative by calling sending an email to **benefits@lapra.org** or calling LAPRA at 213-674-3701.

Domestic Partners

Domestic partners may be enrolled for coverage according to the applicable plan procedures as described in the Eligibility Guide which is available at **www.lapra.org** on the Tools & Resources page.

Medicare Part D

In 2003, the Federal Government voted to expand Medicare coverage to include Pharmacy coverage known as Medicare Part D. This became effective January 1, 2006. If enrolled in a LAPRA medical plan, you and your covered dependents already have pharmacy benefits provided by LAPRA through Anthem Blue Cross and Kaiser that are much better than those available through Medicare Part D. Therefore, the Federal Government has encouraged plans such as ours to continue to provide pharmacy coverage.

Notice Regarding Women's Health & Cancer Rights Act

In compliance with the Women's Health and Cancer Rights Act of 1998, the plans offered under the Los Angeles Police Relief Association, Inc. provide for mastectomy-related services, including reconstruction and surgery to achieve a symmetrical appearance, prostheses and services in connection with physical complications at all stages of mastectomy, including lymphedemas. Benefits for these services will be provided in a manner determined in consultation with the attending physician and the patient. If you have any questions regarding these benefits, please call Anthem Blue Cross PPO at 800-289-2250, Anthem Blue Cross CaliforniaCare Plus HMO at 800-289-2250 or Kaiser HMO at 800-464-4000.

Notice Regarding Newborns' and Mothers' Health Protection Act

This notice is required by the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child not less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother and her newborn earlier than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

Notice of Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a plan offered by LAPRA if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after the other coverage ends or after the employer stops contributing toward the other coverage (60 days if you are requesting enrollment due to loss of eligibility for Medi-Cal or Healthy Families Program coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents. However, you must request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption.

Member Requirement to Notify LAPRA of a Change of Address and Status of Dependents

It is your responsibility to promptly notify LAPRA if (1) you have an address change, or (2) you get divorced or dissolve a domestic partnership. LAPRA does not provide coverage for former spouses, former domestic partners, or for children who do not qualify as dependents under the plan. You have 31 days from the date of the final divorce decree or domestic partnership dissolution to notify LAPRA of a divorce or dissolution of a domestic partnership.

In the case of divorce, failure to provide timely notification may jeopardize your or your dependent's eligibility for COBRA continuation coverage.

Anthem Blue Cross Binding Arbitration Notice

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or *agreement*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under the BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *member* and Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedures 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

The *member* and Anthem agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the *member waives* any right to pursue, on a class basis, any such controversy or claim against Anthem and Anthem waives any right to pursue on a class basis any such controversy or claim against the *member*.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the *member* making written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *member* and Anthem, or by order of the court, if the *member* and Anthem cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

Important Notice from the Los Angeles Police Relief Association (LAPRA) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage, under one of the following LAPRA-sponsored plans (the "Plan") and about your options under Medicare's prescription drug coverage:

- Anthem PPO Medical Plan
- Anthem HMO Medical Plan
- Anthem HMO Medicare Adv Plan
- Kaiser HMO Medical Plan

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. LAPRA has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected.

Although your LAPRA coverage will not be affected if you decide to join a Medicare drug plan, your LAPRA premiums will be higher, *if you are retired,* and you and/or your spouse decide not to enroll in Medicare D through LAPRA or enroll in another Medicare D plan.

If you decide to join a non-LAPRA Medicare drug plan and drop your current LAPRA Medicare D Plan coverage, you may be able to enroll back in the Plan, if you remain eligible under the Plan for such enrollment. However, LAPRA reserves the right to amend or terminate the Plan at any time and there are no vested benefits under the Plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with LAPRA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact a Benefits Service Representative at LAPRA for further information at 213-674-3701. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through this Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage,

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice Date:	April 2024
Name of Entity/Sender:	Los Angeles Police Relief Association, Inc.
Contact-Position/Office:	Benefits Department
Address:	600 N. Grand Avenue, Los Angeles, CA 90012-2212
Phone Number:	213-674-3701
Email:	**benefits@lapra.org**

Premium Assistance Under Medicaid and the 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.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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 one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility.

State	Website	Telephone
Alabama – Medicaid	http://myalhipp.com/	1-855-692-5447
Alaska – Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861
Arkansas – Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
California – Medicaid	Health Insurance Premium Payment (HIPP) Program: http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 FAX: 916-440-5676
Colorado – Health First Colorado & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	HFC: 1-800-221-3943 / State Relay 711 CHP+: 1-800-359-1991 / State Relay 711 HIBI: 1-855-692-6442
Florida – Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia – Medicaid	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, Press 1 678-564-1162, Press 2
Indiana – Medicaid	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid/	1-877-438-4479 1-800-457-4584
Iowa – Medicaid & CHIP (Hawki)	Medicaid Website: https://dhs.iowa.gov/ime/members Hawki Website: http://dhs.iowa.gov/Hawki HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
Kansas – Medicaid	https://www.kancare.ks.gov/	1-800-792-4884 HIPP Phone 1-800-967-4660
Kentucky – Medicaid	KI-HIPP Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	1-855-459-6328 1-877-524-4718

State	Website	Telephone
Louisiana – Medicaid	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid hotline 1-888-342-6207 LaHIPP 1-855-618-5488
Maine – Medicaid	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 1-800-977-6740 TTY: Maine relay 711
Massachusetts – Medicaid & CHIP	https://www.mass.gov/masshealth/pa E-mail: masspremassistance@accenture.com Email: masspremassistance@accenture.com	1-800-862-4840 TTY:711
Minnesota – Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri – Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana – Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska – Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada – Medicaid	http://dhcfp.nv.gov	1-800-992-0900
New Hampshire – Medicaid	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
New Jersey – Medicaid & CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
New York – Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina – Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota – Medicaid	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma – Medicaid & CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon – Medicaid	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania – Medicaid & CHIP	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island – Medicaid & CHIP	http://www.eohhs.ri.gov/	1-855-697-4347, or Direct RIte Share Line 401-462-0311
South Carolina – Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota – Medicaid	http://dss.sd.gov	1-888-828-0059
Texas – Medicaid	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah – Medicaid & CHIP	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont – Medicaid	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia – Medicaid & CHIP	https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington – Medicaid	https://www.hca.wa.gov/	1-800-562-3022
West Virginia – Medicaid & CHIP	https://dhhr.wv.gov/bms/ https://mywvhipp.com/	Medicaid: 304-558-1700 CHIP Toll-free: 1-855-699-8447
Wisconsin – Medicaid & CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming – Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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

Your Rights and Protections Against Surprise Medical Bills for Enrollees in a LAPRA Medical Plan Administered by Blue Cross of California

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

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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 the provider or facility may bill you 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're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

California law protects enrollees in state regulated plans from surprise medical bills when an enrollee receives emergency services from a doctor or hospital that is not contracted with the patient's health plan or medical group. In covered circumstances, providers cannot bill consumers more than their in-network 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 providers there may be out-of-network. 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 can't 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 **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

California law protects enrollees in state regulated plans from surprise medical bills when an enrollee receives scheduled care at an in-network facility such as a hospital, lab, or imaging center, but services are delivered by an

out-of-network provider. In covered circumstances, providers cannot bill consumers more than their in-network cost sharing. Further, for uninsured individuals, hospitals must provide the patient with a written estimate of the amount the hospital will require for the expected services at the time of service.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was 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've been wrongly billed, you may contact 1-888-466-2219 for enforcement issues related to state regulated plans or 1-800-985-3059 (**https://www.cms.gov/nosurprises/consumers**) for enforcement issues related to federally regulated plans.

Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Visit **www.HealthHelp.ca.gov** for more information about your rights under state law.

LAPRA

LOS ANGELES POLICE RELIEF ASSOCIATION, INC.