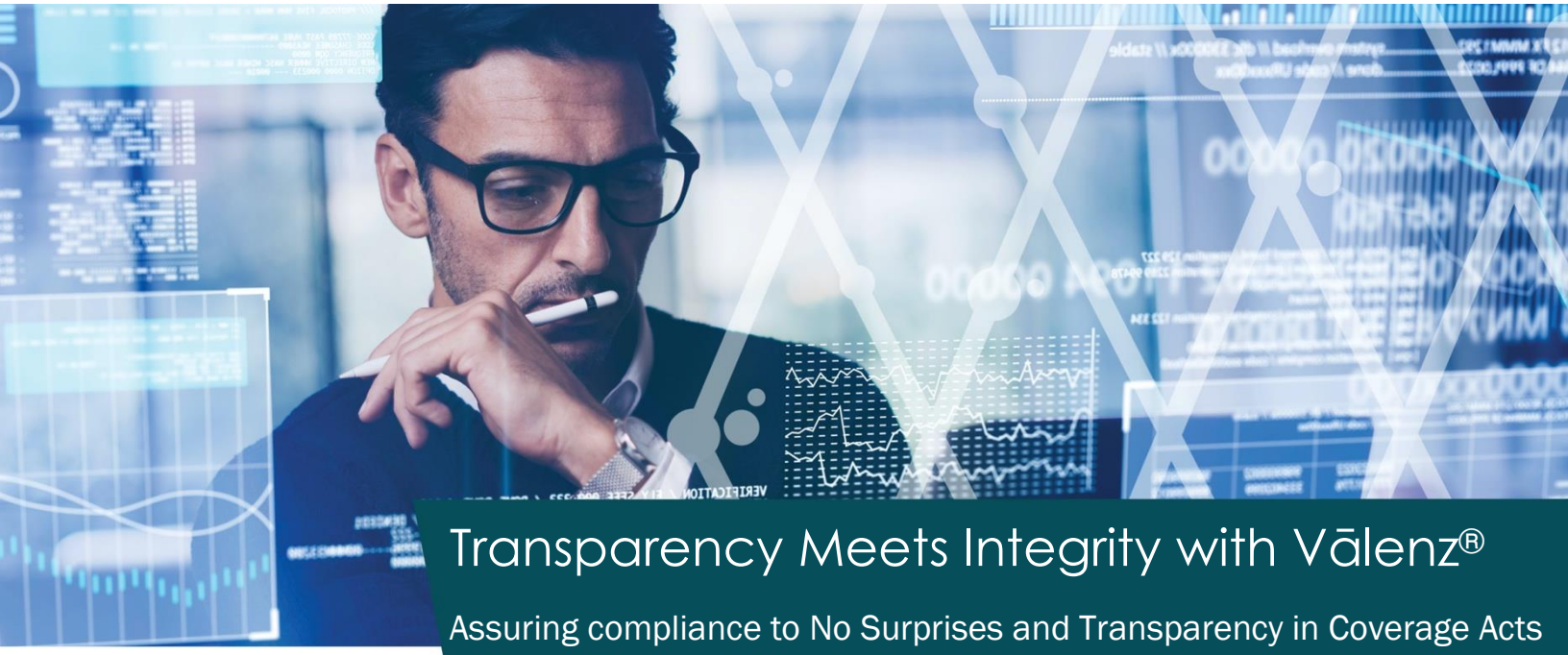
(866) 762.4455
valenzhealth.com



Transparency Meets Integrity with Vālenz®

Assuring compliance to No Surprises and Transparency in Coverage Acts

As industry prepares to implement the federally mandated procedures for protecting patients from surprise medical bills and delivering increased transparency for medical costs and coverage under the **No Surprises and Transparency in Coverage Acts**, Valenz is charting its Roadmap to assure compliance. Via the Roadmap, Valenz, together with its ecosystem partners, will assist health plans and TPAs in navigating their organizations toward compliance, while delivering added value along the way.

Transparency Meets Integrity

At Valenz, we believe complying with the No Surprises and Transparency in Coverage Acts requires data transparency, as well as an infrastructure that enables a high level of integrity to deliver **real value**: solutions that positively affect the quality, utilization and cost of healthcare.

The Valenz ecosystem together with v-Lens, its proprietary data engine, reveals unique levels of data to support Valenz transparency solutions, while providing a foundation for its ecosystem partners to comply with the No Surprises and Transparency in Coverage Acts.

To assist our clients in achieving compliance, Valenz is:

- engaging with TPA and plan partners to identify their specific needs and requirements
- initiating partnership discussions with data aggregators for and on behalf of our TPA clients
- preparing systems to deliver machine-readable files
- accelerating the development of its member portal to complement health plan requirements in more efficiently identifying cost and quality data

Turn the page for additional details about how the No Surprises and Transparency in Coverage Acts apply to self-insured and fully insured plans.

No Surprises and Transparency in Coverage Acts
for Self-Insured and Fully Insured Plans

No Surprises Act		
Mandate	**Requirements***	**Deadline**
Balance billing protections	Mandates a uniform level of protection for out-of-network emergency facility and services, air ambulance transports and out-of-network services delivered at or ordered from an in-network facility	January 1, 2022
Independent Dispute Resolution	Independent Dispute Resolution (IDR) performed by unbiased, third-party arbitrator to establish a qualifying payment amount	January 1, 2022
ID card requirements	Member ID cards must present in-network and out-of-network deductible and out-of-pocket maximum limitations	January 1, 2022
Advanced Explanation of Benefits (EOB)	Providers or facilities must provide the health plan a good faith cost estimate, including billing and diagnostic codes; the plan must then provide member with an Advanced EOB per specifications	January 1, 2022
Continuity of care	If providers or facilities change from in-network to out-of-network, members with ongoing medical care may receive in-network cost-sharing rates for 90 days	January 1, 2022
Price comparison tool	Health plans must create and maintain an online price comparison tool for member use which includes out-of-pocket cost comparisons for in-network providers and facilities	January 1, 2022
Provider directories	Health plans must create an online directory of contracted providers and facilities and validate network information every 90 days; member communication requirements are also included	January 1, 2022
Transparency in Coverage Act		
Public disclosures	Health plans must post machine-readable files on a public website (in-network rates, out-of-network allowed amounts, prescription drug negotiated rates)	January 1, 2022
Participant disclosures	Health plans must provide online self-service cost-sharing and rate information tools; plans must also supply information via paper upon request	January 1, 2023

*Subject to change based on updates in regulations