Medical Bill Rights and Protections

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. You should only be charged your plan's copayments, coinsurance, and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" providers and facilities have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Balanced Billing Protection

You are protected from balance billing for services including the following:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or hospital, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in a stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. If your insurance ID card says "fully insured coverage," you cannot give written consent and give up your protections not to be balance billed for post-stabilization services.

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 can bill you is your plan's in- network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

If you get other types of 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. If your insurance ID card says "fully insured coverage", you cannot give up your protections for these other services if they are a surprise bill. Surprise bills are when you are at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.

Services referred by your in-network doctor
If your insurance ID card says "fully insured coverage", surprise bills include situations when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers cannot balance bill you and may not ask you to give up your protections to not be balance billed. You may need to sign a form (available on the Department of Financial Services' website) for the full balance billing protection to apply.

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing is not allowed, you also have the following protections:</u>

- 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 any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

Additional Resources
For further information regarding Emergency Department physician self-pay pricing, contact our billing agent, Change Healthcare Customer Service at 800-658-5138.

If you believe you have been wrongly billed, and your coverage is subject to New York law ("fully insured coverage"), contact the New York State Department of Financial Services at 1-800-342-3736 or surprisemedicalbills@dfs.ny.gov. Learn more about your rights under state law.

You can also contact the HHS No Surprises Helpdesk at 1-800-985-3059, which is the entity responsible for enforcing the federal balance or surprise billing protection laws. Visit cms.gov/nosurprises/ consumers for more information about your rights under federal law.