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Your Rights and Protections Against Surprise Medical Bills

You are protected from balance billing when you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center. In these cases, you shouldn't be charged more than 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 <u>out-of-pocket costs</u>, such as copayments, <u>coinsurance</u>, and/or a <u>deductible</u>. You may have additional costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities without a contract with your health plan to provide services. Out-of-network providers may 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 schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Depending on the procedure or service, surprise medical bills could cost thousands of dollars.

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 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 stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center: Certain providers may be out of network when you get services from an in-network hospital or ambulatory surgical center. 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, or intensivist services. These



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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 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.

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

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

- You are only responsible for paying your share of the cost (like copayments, coinsurance, and deductibles you would pay if the provider or facility was in network). Your health plan will directly pay any additional costs to out-of-network providers and facilities.
- Generally, your health plan must:
 - Cover emergency services without requiring 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 or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact 1-800-985-3059.

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