St. Claire

UK ST. CLAIRE SURPRISE BILLING

Understanding Your Rights and Protections Against Surprise Medical Billing

When you receive emergency care or are treated by an out-of-network provider at an in-network hospital or surgery center, you are protected from balance billing. This means you shouldn't have to pay more than your plan's usual copayments, coinsurance, or deductible.

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

When you visit a doctor or other health care provider, you may need to pay some out-of-pocket costs [link: https://www.healthcare.gov/glossary/out-of-pocket-costs], such as a copayment [link: https://www.healthcare.gov/glossary/co-payment], coinsurance [link: https://www.healthcare.gov/glossary/co-insurance], or deductible [link: https://www.healthcare.gov/glossary/deductible]. If the provider or facility isn't in your health plan's network, you could have additional costs—or even the full bill.

- **"Out-of-network"** refers to providers and facilities that don't have a contract with your health plan. These providers may be allowed to bill you for the difference between what your plan covers and the full cost of the service. This is called "balance billing." It's usually more expensive than in-network care and might not count toward your plan's deductible or yearly out-of-pocket maximum.
- **"Surprise billing"** happens when you get an unexpected balance bill. This can occur if you don't have control over who treats you—like during an emergency, or when you go to an in-network facility but are unexpectedly seen by an out-of-network provider. Depending on the service, these surprise bills can cost thousands of dollars.

You're protected from balance billing for the following:

If you get emergency care or are treated by an out-of-network provider at an in-network hospital or surgery center, you're protected from balance billing. This means you shouldn't have to pay more than your usual copay, coinsurance, or deductible.

Emergency Services

If you have a medical emergency and receive care from an out-of-network provider or facility, they can only charge you the same costs you would pay in-network—like your copay, coinsurance, or deductible. You can't be balance billed for this emergency care. This also includes care you may get after you're stable, unless you agree in writing to give up your protection from balance billing for services received post-stabilization.

Certain Services at In-Network Hospitals or Surgery Centers

Even if you go to an in-network hospital or surgery center, some of the providers who treat you might be out-of-network. In these situations, they can only charge you what you would normally pay in-network. This rule applies to services like emergency care, anesthesia, pathology, radiology, lab work, neonatology, assistant surgeons, hospitalists, and intensivists. These providers are not allowed to balance bill you or ask you to give up your protections.

If you receive other types of care at an in-network hospital or surgery center, out-of-network providers are not allowed to balance bill you—unless you agree in writing to give up your protections.

You never have to give up your protection from balance billing. You also don't have to get care from an out-of-network provider. You can always choose a doctor or facility that's in your insurance network.

What This Means for You

When balance billing isn't allowed, as in the circumstances listed above, you have these additional protections:

- You're only responsible for paying your part of the cost—like your copay, coinsurance, or deductible—just as you would if the provider or facility was in-network. Your health plan will pay the rest directly to the out-of-network provider or facility.

In most cases, your health plan must:

- Cover emergency services without needing prior approval (also called "prior authorization").
- Cover emergency care from out-of-network providers.
- Base your share of the cost on what it would pay an in-network provider and include that amount in your explanation of benefits.
- Count what you pay for emergency or out-of-network care toward your in-network deductible and out-of-pocket maximum.

If you believe you were wrongly billed, call the Federal No Surprises Helpdesk at 1-800-985-3059.

To learn more about your rights under federal law, visit www.cms.gov/nosurprises/consumers.

You have the right to receive a "Good Faith Estimate" that explains how much your health care may cost.

By law, health care providers must give you an estimate of your expected charges if you don't have certain types of insurance or if you're not using your insurance. **This estimate should be provided before you receive care.**

- You can ask for a Good Faith Estimate when you schedule a service or even before you schedule. It should include the full expected cost of your care, including things like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a service at least 3 business days in advance, the provider must give you a written estimate within 1 business day. If you schedule it at least 10 business days in advance, they must give you the estimate within 3 business days. You can also request one at any time, and the provider must respond with a written estimate within 3 business days.
- If you get a bill that's $400 or more above your Good Faith Estimate from the same provider or facility, you can dispute the bill.
- **Be sure to save a copy or photo of both your Good Faith Estimate and your bill.**

For questions or more information, visit www.cms.gov/nosurprises/consumers or email FederalPPDRQuestions@cms.hhs.gov.

You can also call the Federal No Surprises Helpdesk at **1-800-985-3059**.

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