PRAIRIESTATES

Your Rights and Protections Against Surprise Medical Bills

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 or 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 network serving 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 maximum.

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.

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You Are Protected from Balance Billing for the Following Situations:

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 NOT be balance billed for these emergency services beyond these cost-sharing amounts. 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 balance billed for these 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 that perform services at those facilities 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 NOT 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 NOT balance bill you, unless you give written consent and give up your protections.

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

When Balance Billing Isn't Allowed, You Also Have the Following Protections:

For the above situations noted, you are only responsible for paying your share of the cost under your plan (like copayments, coinsurance and deductible that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly when billed.

Generally in the above situations, your health plan must:

- Cover emergency services without requiring you to get pre-approval for services in advance (pre-certification or prior authorization).
- Cover emergency services by out-of-network providers at in-network benefit levels.
- 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 (EOB).
- 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 have been wrongly billed and need more information or contacts, you may visit No Surprises Act | U.S. Department of Labor (dol.gov).