Your Rights and Protections Against Surprise Medical Bills

On January 1, 2022, the ***No Surprises Act*** becomes effective. This federal law, which Congress passed as part of the Consolidated Appropriations Act of 2021, is intended to provide patients with peace of mind and notify you about your consumer protections from unexpected medical bills from providers of care (both facilities and practitioners). The No Surprises Act also enables uninsured patients to receive a good faith estimate of the cost of care.

Billing Disclosures – 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" (sometimes called "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. However, when you see an **"out-of-network"** doctor or facility, you may have higher out-of-pocket costs or have to pay the entire bill when that provider or facility is **not** in your health plan's network.

"Out-of-network" describes providers or facilities that do not have a signed 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.

"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. Receiving care from an out-of-network provider or facility **by choice** could also cost you more. **This new law requires us to ask whether you would like to give up those protections and pay more for out-of-network care. Your written consent will be required.**

This new law protects you 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for 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 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 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't balance bill you and may not ask you to give up your protections not to be balance billed.

This requirement is mandated by Section 2799B-3 of the Public Health Service Act (PHS Act).

If you receive other 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 are never required to give up your protections from balance billing. You also aren't 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:

- 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 out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

Good Faith Estimate

You have the right to receive a **"Good Faith Estimate"** explaining how much your medical care will cost.

Under the law, healthcare providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your healthcare provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate at the time you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Please contact our office for questions or dispute the bill.

- Be sure to save a copy or picture of your Good Faith Estimate for your records.

Get More Information

For more information about your rights and protections:

Visit the **Centers for Medicare & Medicaid Services** website at **https://www.cms.gov/nosurprises** for more information about your rights under federal law.

You may also contact **your health plan** or your **local Health and Human Services Office** in your county.

If you think you have been wrongly billed, you may:

- Contact the care provider to question or dispute the bill.
- You may also initiate the patient-provider dispute resolution process with the U.S. Department of Health and Human Services (HHS) for a small fee if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate, as specified in 45 CFR 149.620.
  To learn more and get a form to start the process, visit **https://www.cms.gov/nosurprises** or call **1-800-985-3059**.
- Contact your health plan to ask them why you received the bill and if it's correct. If it was an emergency, ask your health plan if they processed your claim as an emergency.
- Contact the U.S. Centers for Medicare & Medicaid Services (CMS). Visit https://www.cms.gov/nosurprises for more information about your rights under federal law or call **1-800-985-3059**.
- Visit the **Missouri Department of Insurance** for more information about your rights under Missouri law at **https://insurance.mo.gov/consumers/health/index.php**
- Contact the **Illinois Department of Insurance** for more information about your rights under Illinois law at **DOI.InfoDesk@illinois.gov**
- You may also contact your **local Health and Human Services Office** in your county.

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