Your Rights and Protections Against Surprise Medical Bills

When you are treated by an out-of-network provider or healthcare facility, you are protected from balance billing. 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 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 isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't 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.

You're 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
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, 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.

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 never 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.

In addition to the No Surprise billing laws, Idaho healthcare entities and providers must also comply with the Idaho Patient Protection Act when billing patients. This requires all Idaho healthcare providers and entities to do the following on any service provided:

- Must submit charges to third-party payors identified by the patient within 45 days of the service(s) being provided. If no third-party payor(s) was identified, submit charges to the patient.
- Must send a consolidated summary of services from the healthcare facility visited within 60 days of the service(s) being provided. Unless, 1) the patient receives a final statement from a single billing entity for all goods and services provided to the patient at that healthcare facility; 2) the patient was informed in writing of the name, phone number, and address of the billing entity; 3) and the healthcare facility complies with the other statutory provisions.
- Must send a final statement to patient. The healthcare provider/entity may not charge interest until at least 60 days have passed since the patient received the final statement (63 days after mailed). The healthcare provider may not pursue extraordinary collection action until at least 90 days have passed since patient received the final statement (93 days after mailed).

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible 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.

If you think you've been wrongly billed, contact your state representatives or the Centers for Medicare and Medicaid Services at 1-800-985-3059. Your state website can be found at www.[enter your state name].gov and by searching "no surprises, balance billing or consumer protections". Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.