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HR

**Surprise Billing Act - Patient Protections**

(Effective 01/01/2022)

**Your Rights and Protections Against Surprise Medical Billing**

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 balancing billing.

**What is “balancing billing” (sometimes called “surprise bill”)?**

When you see a doctor of 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 health plan.

Out-of-network providers may be permitted to bill you for the differences between what your plan agreed to pay and the full amount charged for the 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 limit.

“Surprise billing” is an unexpected 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.

**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 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 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.

 **2021 Minnesota Statutes - 62K.11 BALANCE BILLING PROHIBITED.**

 (a) A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service. A network provider is permitted to bill an enrollee the approved co-payment, deductible, or coinsurance.

 (b) A network provider is permitted to bill an enrollee for services not covered by the enrollee's

 health plan as long as the enrollee agrees in writing in advance before the service is performed to

 pay for the non-covered service.

 **Colorado HB19-1174, 2019 Regular Session - Out-of-network Health Care Services**

 House Bill (HB) 19-1174 was passed by the Colorado Legislature to help protect patients from surprise

 out-of-network bills. The bill includes provisions for how health insurance carriers will reimburse

 providers (doctors, hospitals and other health care providers) for out-of-network emergency and

 non-emergency care. Legislation and FAQ: HB19-1174 – Out-of-Network Health Care Services

 **Indiana – No Surprise Act - What you should I know?**

 You must receive notice of your rights under the new law from your health plan and from the facilities

 and providers that serve you.

 If you think the protections have not been applied correctly, you can file an appeal with your insurance

 company or request external review of the company’s decision.

 You also can file a complaint with the federal Department of Health and Human Services.

 **Kentucky – See Federal No ‘Surprise Billing Act’**

**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 be balance billed.

If you get 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’re 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.

**If you believe you’ve been wrongly billed**, you may contact:

 If you believe you've been wrongly billed, you may contact: **No Surprises Help Desk (NSHD) at 1-800-985-3059**. Visit **cms.gov/nosurprises** for more information about your rights under federal law.

 Or contact the U.S. Department of Health & Human Services (HHS): 877-696-6775

Visit **hhs.gov** for more information about your rights under federal law. Visit the website of the state you reside in for information on same or similar laws concerning the ‘Surprise Billing Act’.