Your Rights and Protections Against Surprise Medical Bills

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. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health insurance 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 limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot 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 cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Also, see MS Revised Statute 83-9-5-(1)(i).

Certain services at an in-network hospital or ambulatory surgical center

When you get certain services other than emergency 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 services provided by: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** 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 cannot 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 are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing is not allowed, you also have the following protections:</u>

- 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 as in-network provider or in-network 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.

January 1, 2022

Your Right to Receive a "Good Faith Estimate"

You have the right to receive a "Good Faith Estimate" explaining how much your non-emergency medical care may cost.

Under the law, health care providers need to give patients who do not have insurance, or who are not using insurance, a cost estimate of the bill for medical items or 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.

- Your health care provider will give you a "Good Faith Estimate" in writing for services within three days of scheduling (if scheduled at least 10 business days in advance) or within one business day after scheduling (if scheduled at least 3 business days in advance). You can ask your health care provider for a "Good Faith Estimate" before you schedule an item or service; this will be provided within 3 business days after you ask.

- If you receive a bill that is at least $400 more than your "Good Faith Estimate," you can dispute the bill.

Additional information is available upon request. If you believe you've been wrongly billed, you may contact the Compliance Office.

Visit the Centers for Medicare and Medicaid Services at www.cms.gov/nosurprises for more information about your rights under federal law.

Visit Mississippi Insurance Commissioner's website at www.mid.ms.gov for more information about your rights under Mississippi law.

January 1, 2022