A Patient's Rights & Protections Against Surprise Medical Bills

No Surprise Billing

When a patient receives emergency care or gets treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, they are protected from surprise billing or balance billing.

What is "balance billing?"

(sometimes called "surprise billing")

If a patient sees a doctor or other healthcare provider, they may owe certain out-of-pocket costs, such as a copayment, coinsurance or a deductible. A patient may have other costs or have to pay the entire bill if they see a provider or visit a healthcare facility that is not in their health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill a patient for the difference between what their 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 a patient's annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill that can happen when a patient cannot control who is involved in their care—like when they have an emergency or when they schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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

When a patient receives 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 a patient is their 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 cannot balance bill a patient and may not ask a patient to give up their protections not to be balance billed.

If a patient receives other services at these in-network facilities, out-of-network providers cannot balance bill them, unless the patient gives written consent and gives up their protections.

A patient is never required to give up their protections from balance billing, nor are they required to receive care out-of-network. A patient can choose a provider or facility in their plan's network.

When balance billing is not allowed, a patient also have the following protections:

A patient is only responsible for paying their share of the cost (like the copayments, coinsurance and deductibles they would pay if the provider or facility was in-network). A patient's health plan will pay out-of-network providers and facilities directly. Their health plan generally must:

- Cover emergency services without requiring the patient to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what the patient owes the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in their explanation of benefits.
- Count any amount the patient pays for emergency services or out-of-network services toward their deductible and out-of-pocket limit.

If a patient believes they have been wrongly billed, they may contact 1-800-985-3059 to submit a complaint regarding potential violations of the No Surprises Act.

Visit www.cms.gov/nosurprises for more information about patient rights under federal law.

No Surprises Disclosure 4-15-22

211 Saint Francis Drive | Cape Girardeau, MO 63703 | 573-331-5217 | www.sfmc.net