

# 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. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare 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 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 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 balance 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 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.

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.

*Missouri law provides that health care professionals who send a claim for charges for unanticipated out-of-network care to the patient's health plan may not bill the patient for any difference between the reimbursement rate determined under Missouri law and the health care professional's billed charges. Patients, however, remain responsible for their cost-sharing requirements, such as the in-network deductible and out-of-pocket maximum, for such charges. Section 376.690 of the Missouri Revised Statutes defines "unanticipated out-of-network care" as health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged. This law applies only to services received for an emergency medical condition and applies only to health insurers that are subject to Missouri law.*

**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:

1. Cover emergency service without requiring you to get approval for services in advance (prior authorization).
2. Cover emergency service by out-of-network providers.
3. 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.
4. 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:**

The No Surprises Help Desk at 1-800-985-3059 or visit <https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing> or

Missouri Department of Insurance

Address: PO Box 690, Jefferson City, MO 65102-0690

Telephone: (573) 751-4126 Email: [news@difp.mo.gov](mailto:news@difp.mo.gov)

website: <https://insurance.mo.gov/consumers/health/managingcost.php>

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