Your Rights and Protections Against Surprise Medical Bills

You are protected from surprise billing or balance billing when you receive emergency care or receive treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center(ASC).

"Balance Billing & Surprise Billing" When you see a doctor or other healthcare provider, you may owe certain out of pocket costs, like a copayment, coinsurance, or deductible. If you see a healthcare provider or visit a healthcare facility that is not in your health plan's network, you may have higher costs or have to pay the entire bill.

"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 you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balanced billing." This amount is likely more than what in-network costs for the same service would be, and it might not count towards your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. An example of this is when you have an emergency and are at an in-network facility but receive treatment 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/facility may bill you is your plan's in-network cost-sharing amount. You cannot be balance 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.

Certain Services at an In-network Hospital or ASC.
When you receive services from an in-network hospital or ASC, certain providers there may be out-of-network. In these casses, 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 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.

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

- You are only responsible for paying your share of the cost (like 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 have been wrongly billed, you may contact the billing office at (405) 705-0018. For more information regarding the No Surprise Billing Act visit www.cms.gov/nosurprises/consumers or if you prefer call 1-800-985-3059.

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