Your Rights and Protections Against Supervise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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.

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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

State of Oregon Guidelines

Surprise billing happens when you get an unexpected bill after you receive care from an out-of-network provider or at an out-of-network facility, such as a hospital. It can happen for both emergency and nonemergency care. Typically, patients don't know the provider or facility is out of network until they receive the bill.

Surprise medical bills typically are sent by your health care provider for the remaining charges for services you received that are not covered by your insurance (known as balance billing). The new law protects consumers from either of the following situations:

- Emergency services provided out of network, including air ambulance services (but not ground ambulance services)
- Nonemergency services provided by an out-of-network provider at an in-network facility

In an emergency situation, a facility or provider may not bill you more than your in-network co-insurance, co-pays, or deductibles for emergency services as outlined in your plan documents, even if the facility or provider is out of network. However, if your health plan requires you to pay co-insurance, co-pays, or deductibles for in-network care, you are still responsible for those.

In a nonemergency situation, out-of-network providers (such as an anesthesiologist) may not bill you more than your in-network co-insurance, co-pays, or deductibles for covered services performed at an in-network facility without your consent.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- **Generally, your health plan must:**
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact Oregon's Division of Financial Regulation by calling 888-877-4894 (toll-free) or emailing **DFR.InsuranceHelp@dcbs.oregon.gov** or by visiting https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx. Contact the federal phone number for information and complaints is: 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit https://dfr.oregon.gov/news/2021/pages/20211230-new-law-protects-consumers.aspx or for more information about your rights under Texas state laws.