

Your Rights and Protections Against Surprise Medical Bills

For services provided on or after January 1, 2022

When you receive emergency care or are 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, like 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 plan. 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 the 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.

You’re protected against balance billing if:

You participate in a commercial or self-funded insurance plan.

You’re protected from balance billing for:

Emergency services

If you have an emergency medical condition and receive emergency services at a hospital emergency department or freestanding emergency department, the most an out-of-network provider or facility may bill you for such emergency services 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 waive your protections against balance billing for these post-stabilization services.

In addition to the protections under the federal No Surprises Act, the state in which you receive services may have protections that apply to your visit. Under NY law, if your NY insurance card says “fully insured coverage” you can’t give written consent and waive protections against balance billing for post-stabilization services. NJ, NY, CT, and PA limit the amount an out-of-network provider and facility can bill you for emergency services to your in-network cost sharing amount. OR limits the amount an out-of-network provider can bill you for emergency services to your in-network cost sharing amount.

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

Should you receive emergency medicine, anesthesia, pathology, radiology, laboratory, assistant surgeon, or hospitalist services by Summit Health out of network providers while you are at an in-network hospital or ambulatory surgical center, the most you would be billed is your plan’s in-network cost-sharing amount. 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 waive protections against 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.

The state in which you receive services may also have protections that apply to non-emergency services at an in-network facility --

- **CT:** You may not be balance billed for surprise bills in the following circumstances: (1) an out-of-network clinical laboratory if you were referred by an in-network provider; or (2) an out-of-network provider at an in-network facility for a service or procedure that was performed by an in-network provider and you did not knowingly elect to receive those services from the out-of-network provider. A bill is not a surprise bill if an in-network provider is available, but you knowingly elect to receive services from an out-of-network provider. If you receive a surprise bill, you are only required to pay your plan's cost-sharing amount.
- **NJ:** You may not be balance billed above your plan's in-network cost-sharing amount for: inadvertent out-of-network services (meaning services that are covered under your health plan and are provided by out-of-network providers in an in-network facility when in-network services are unavailable or not made available to you, including laboratory testing); and out-of-network services provided on an emergency or urgent basis.
- **NY:** If your NY insurance ID card says "fully insured coverage", you cannot waive your protection against receiving a surprise bill for (1) services at an in-network facility, or (2) services by an out-of-network provider where your in-network provider refers you without your consent.
- **PA:** If you have a PPO plan and require emergency services, your plan will pay for the emergency services so that you are not liable for out-of-pocket expenses greater than if you had received for services from a preferred provider. If you have an HMO plan, emergency services are covered in and out of your service area and are not limited to affiliate providers. No emergency room copayment in excess of primary care payment may be charged if you are referred to the emergency room by a primary care physician or the HMO and the services could have been provided in the primary care physician's office.
- **OR:** You may not be balance billed for surprise bills for inpatient or outpatient services provided at an in-network health care facility.

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 deductibles 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 by a Summit Health facility or provider, please contact us at 908-790-6500 (Summit Health), 516-783-4600 (CityMD), 541-317-4200 (Summit Health Oregon), 877-336-5876 (NJU), and 914-681-3110 (WestMed).

Alternatively, you may contact CMS at 1-800-985-3059 or visit <http://www.cms.gov/nosurprises/consumers> for information about your rights under federal law. You may also contact your applicable state agency --

- CT: Contact Department of Insurance at 860-297-3900 or 1-800-203-3447 or <https://portal.ct.gov/CID/Consumer-Affairs/File-a-Complaint-or-Ask-a-Question>.
- NJ: Contact Department of Banking and Insurance at 609-292-7272 or 1-800-446-7467 or <https://www.state.nj.us/dobi/consumer.htm>.
- NY: Contact Department of Financial Services at 1-800-342-3736 or <https://www.dfs.ny.gov/complaint>.
- PA: Contact Insurance Department at 877-881-6388 or 717-783-3898 or www.insurance.pa.gov/NoSurprises.
- OR: Contact Division of Financial Regulation at 888-877-4894 or <https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx>.