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, like a copayment, coinsurance, or deductible. You may have additional costs 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 deductible). 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.

In Arizona, providers are prohibited from billing you for amounts beyond the in-network level cost share, unless the below disclosure guidelines are met prior to services being performed.

The above protection applies:

- Protections apply to health plans that cover out-of-network care and HMO enrollees
- To HMO and PPM enrollees
- For emergency services provided by out-of-network professionals at in-network facilities
- For non-emergency services provided by out-of-network professionals at in-network facilities

Protections do not apply to:

- ground ambulance services, services at out-of-network facilities, enrollees who consent to non- emergency out of network services, enrollees in self-funded plans.

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

Under Arizona law, if you received health care services at an in-network facility you may seek arbitration of qualifying out-of-network bills. Arizona provides a dispute resolution process for claims over $1,000.00, which must be submitted by you as the enrollee.

- Arizona requires the arbitrator to provide the following for informed decision: 1) the average contracted amount insurers pay for the services in the county, 2) the average amount the provider has contracted to accept for the services at issue, 3) Medicare and Medicaid reimbursement rates, 4) the providers direct pay rate for the services at issue

- The provider must give the enrollee a written, dated disclosure "a reasonable amount of time" before the services are provided. The disclosure requires 1) a notice with providers name and out-of-network status, 2) estimated total cost, 3) notice that the enrollee is not required to sign to obtain care, but if signed they are waiving rights to dispute resolution.

You are not protected, for non-emergency services, if the provider follows these rules for disclosure but if you decline to the disclosure agreement the protections still apply.

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 the Arizona Department of Insurance and Financial Institutions at (602) 364-3100. 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 or call (800) 985-3059.

Visit https://difi.az.gov/consumer/i/health/surprisebill for more information about your rights under Arizona law.