Your Rights and Protections Against Surprise 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. For definitions, visit https://www.healthcare.gov/glossary/

"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.

In accordance with the Nebraska Out-of-Network Emergency Medical Care Act, if you receive emergency services from any health care providers, such providers are not permitted to bill you in excess of any deductible, copayment, or coinsurance amount applicable to in-network providers' emergency services pursuant to your health benefits plan. Your insurer is obligated to make sure you do not incur out-of-pocket costs greater than the out-of-pocket costs you would have incurred had you received emergency services from an in-network health care provider.

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.

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 provider that sent you the bill. For York General Hospital billing statements, contact the York General Patient Accounts billing department supervisor at 402-362-0435. 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. For Nebraska regulation contact the Nebraska Department of Insurance at 402-471-2201, or call the toll-free consumer hotline at 1-877-564-7323. Additional information is available at their website: www.doi.nebraska.gov or https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerFactSheetBalanceBillingandOutofNetworkProviders.pdf

These protections apply to consumers who get coverage through their employer (including a federal, state, or local government), through the Health Insurance Marketplace® or directly through an individual health plan, beginning January 1, 2022. The rules do not apply to people with coverage through governmental programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE because these programs have other protections against high medical bills.

In addition, protections apply to consumers who don't have insurance by receiving a "Good Faith Estimate". The rule makes sure consumers know how much their health care will cost before they get treatment and might help them if they get a bill that's larger than expected.