

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 surprise billing or 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, such as 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 isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what the plan agreed to pay 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 your 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 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 or facility may 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 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 (hospital services), or intensivist services (intensive/critical care 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 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 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 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.

State Law (Non-Emergency Hospital Services)

If you are receiving non-emergency hospital services and if you do not have health coverage or if you have health insurance with an insurance deductible of five thousand dollars (\$5,000) or higher, you have the right under Rhode Island law to request that the hospital provide you with a written estimate of the amount the hospital will require you to pay for the health care services, procedures, and supplies that are reasonably expected to be provided to you by the hospital, based on an average length of stay and services provided for your diagnosis and including the amount for any facility fee required. The estimate must be provided within five (5) calendar days. The estimate may indicate that it does not reflect any unanticipated services that become apparent at the time of treatment. The hospital may provide this estimate during normal business office hours. In addition to the estimate, the hospital must provide information about its financial assistance and charity care policies, and contact information for a hospital employee or office from which the person may obtain further

information about these policies. If you request, the hospital must also provide you with an application for financial assistance or charity care.

If you believe you've been wrongly billed, you may contact the Rhode Island Insurance Division of the Department of Business Regulation at 401-462-9520 or DBR.Insurance@dbr.ri.gov.

The federal phone number for information and complaints is: 1-800-985-3059. Visit <https://www.cms.gov/medical-bill-rights> for more information about your rights under federal law.