

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.

“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 hospital, 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 a stable condition.

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, and 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 **can't** give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.

Services referred by your in-network doctor

Surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website at <http://www.dfs.ny.gov>) for the full balance billing protection to apply.

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 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.
- For surprise bills and bills for emergency services, when a surprise bill claim is submitted with an Assignment of Benefits form (effectively discontinued) **or** the issuer otherwise determines that the claim is or could be a surprise bill or balance bill for emergency services, the issuer must provide notice to the insured, by inclusion with or in conjunction with an EOB, that **directs the insured to contact the issuer if the non-participating provider bills the insured for the out-of-network services other than the insured's in-network cost-sharing**
- If health plan determines that a bill could be a surprise bill, notice to insured must indicate that such a claim could be a surprise bill and direct the insured to contact the issuer if the non-participating provider bills the insured for the out-of-network services other than the insured's in-network cost-sharing.

If you think you've been wrongly billed, contact the New York State Department of Financial Services at (800) 342-3736 or surprisemedicalbills@dfs.ny.gov. Visit <http://www.dfs.ny.gov> for information about your rights under state law.

You can also call MetroPlusHealth with any questions or concerns at (800) 303-9626 (TTY:711), Monday through Friday, 8am – 8pm, Saturday, 9am – 5pm.