ColoWell America
Proctology & Aesthetic Care

Your Rights against Surprise Billing

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 balance or surprise billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is surprise billing (also known as balance billing)?

When you see a physician or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or deductible. You may have additional costs if you see a provider or go to a health care facility that is out -of network, and you may even have to pay the entire bill.

"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 known as "balance billing." This amount may be more than in-network costs for the same service and may 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. For example: 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. This could result in a surprise medical bill.

When you have an emergency medical condition and receive emergency medical 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). Balance billing is not permitted for these emergency services. This includes additional medical services you may receive after you have been stabilized, unless you have given written consent and give up your protections not to be balanced billed for these post-stabilization services.

When you receive medical services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most these 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. Balance billing from these providers is prohibited and they may not ask you to give up your protections from being balance billed. If you receive other types of services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

NOTE: You are never required to give up your protection from balance billing, you are not required to receive out-of-network care, you can choose to provider or facility that is in your plan network.

You are only responsible for paying your share of the cost. Such as 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:

- Will cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Will cover emergency services by out-of-network providers.
- Will base what you owe the medical 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 (EOB).
- Will count the 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 have been billed incorrectly, you may contact the Centers for Medicare and Medicaid Services at 1-800-985-3059 or visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

In addition to the Federal No Surprises Act, the state in which you receive medical services may have protections that apply to your visit for emergency or non-emergency services. Additional information is available from your state government. The Federal protections exceed state protections in almost every state.

CA, CT, FL, GA, IA, MD, MI, NJ, NY, OH, and PA limit the amount an out-of-network provider and out-of-network facility can bill you for emergency services. The amount is limited to your in-network cost sharing amount.

DE, IN, IL, MA, and OR limit the amount an out-of-network provider can bill you for emergency services to your in-network cost sharing amount.

CA, CT, DE, FL, GA, MD, MI, and OR establish the amounts providers may be paid.

OH also provides protections relating to lab services.

CA, FL, GA, IL, NJ, NY, and MI have dispute resolution processes.