HMU Houston Metro Urology

No Surprises Act

Transparency for Billing and Insurance at Houston Metro Urology

Effective January 1, 2022, the No Surprises Act (which Congress passed as part of the Consolidated Appropriations Act of 2021) is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable for only in-network cost-sharing amounts. The No Surprises Act also enables uninsured patients to receive a good faith estimate of the anticipated cost of their care.

Your Rights and Protections Against Surprise Medical Bills

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 "surprise billing" – also known as 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, 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. Out-of-network providers may be permitted to bill you for the difference between what your 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 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.

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 and coinsurance). 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 protection not to be balanced billed for these post-stabilization services.

Texas law protects patients with state-regulated health insurance (about 16 % of Texans) from surprise medical bills in emergencies or when they didn't have a choice of doctors. The law bans doctors and providers from sending surprise medical bills to patients in those cases.

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, assist 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 balanced 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.

Texas law also prohibits balance billing for any health care, medical service or supply provided by an in-network facility by an out-of-network physician or other provider and for services by diagnostic imaging providers and laboratory service providers provided in connection with a health care service performed by a network physician or provider.

You're <u>never</u> 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 out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (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 of 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 deductible and out-of-pocket limit.

Third-Party Providers

You may be provided care by third-party healthcare providers. In this event, you have the right to receive a good-faith estimate from all providers that may be involved in your care.

Good Faith Estimate

If you are uninsured or not using insurance for a non-emergency item or service, you have the right to receive a "Good Faith Estimate" explaining how much your medical care might cost *before* you receive such care. This estimate must include:

- A list of items and services that the scheduling provider or facility reasonably expects to provide you for the scheduled visit/services.

- The Good Faith Estimate list must include expected charges or costs associated with each item or service from each provider and facility along with applicable diagnosis and service codes
- A notification that if the billed charges are higher than the good faith estimate, you can ask your provider or facility to update the bill to match the good faith estimate, ask to negotiate the bill, or ask if there is financial assistance available
- Information on how to dispute your bill if it is at least $400 higher for any provider or facility than the good faith estimate you received from that provider or facility (see below)

Questions?

If you believe you've been wrongly billed, or to review more information about your rights (including your right to a Good Faith Estimate), you may contact the U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit cms.gov/nosurprises for more information about your rights under federal law. You may also contact your health plan to ask them why you got the bill and if it's correct. If it was an emergency, ask your health plan if they processed your claim as an emergency. Finally, you may contact the Texas Attorney General's Consumer Hotline at (800) 621-0508.

Visit www.cms.gov/nosurprises for more information about your rights under federal law. Visit www.tdi.texas.gov/medical-billing/surprise-balance-billing.html for more information about your rights under Texas law.