SBH Health System BRONX

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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 should not be charged more than your plan's co-payments, co-insurance and/or deductible.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, like a co-payment, co-insurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a healthcare 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 for your 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-network 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 hospital, the most they can bill you is your plan's in-network cost-sharing amount (such as co-payments, co-insurance, 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. If your insurance ID card says, "fully insured coverage," you **can't** give written consent and give up your protections not be balanced billed for 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 can bill you is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivists services. These providers **can't** balance bill you for and may **not** ask you to give up your protections not to be balanced 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. If your insurance ID card says, "fully insured coverage," 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
If your insurance ID card says, "fully insured coverage," surprise medical bills include when you're 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 to give up your protections not to be balanced billed. You may need to sign a form (available on the Department of Financial Services' website) for the full balance billing protections 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 of 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 co-payments, co-insurance, 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 most:
    - 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 and facility and show that amount in your explanation of benefits
- Count any amount you pay for emergency services or out-of-network services toward you in-network deductible and out-of-pocket limit

If you think you've been wrongly billed and your coverage is subject to New York law ("fully insured coverage"), 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.

For information regarding the Surprise Bills Law:
Open the hyper link: Surprise Medical Bills | Department of Financial Services

For more information or to find a physician employed by St. Barnabas Hospital:
Visit: https://www.sbhny.org/find-a-doctor

For more information or to see a list of non-employed physicians who provide services at St. Barnabas Hospital:
Visit: https://www.sbhny.org/financial-services/physician-practice-groups

To see a list of participating insurance plans:
Visit: https://www.sbhny.org/financial-services

For information about hospital charges:
Open the hyper link: St. Barnabas Hospital