Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get 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.

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 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, or 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 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 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 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 deductible and out-of-pocket limit.
- See Appendix A to this Notice for Information on the Commonwealth of Kentucky protection provisions.

If you believe that you've been wrongly billed:

Please contact Elaine Schaser in the Diocesan Benefits Office at 859-392-1554, or ESchaser@CovDio.org.

APPENDIX A

Commonwealth of Kentucky
Public Protection Cabinet

Andy Beshear, Governor **Ray A. Perry, Secretary**

FOR IMMEDIATE RELEASE

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New Law Protects Kentuckians from Surprise Medical Bills
Begins with 2022 Plans

Frankfort, Ky. (Feb. 2, 2022) – As of Jan. 1, Kentuckians who receive surprise medical bills now have protection against those bills.

"Health care is a basic human right, which is why my administration has fought to expand health care coverage and make it more affordable for all Kentucky families," said Gov. Andy Beshear. "This new law will help make sure our people have protection against unexpected medical bills in an emergency."

Through the federal No Surprises Act, excessive out-of-pocket costs are restricted, and emergency services are covered without any prior authorization, regardless of whether a provider or facility is in-network.

The law applies to health insurance plans starting in 2022, including self-insured health plans that employers offer as well as plans from health insurance companies.

Prior to the legislation, if consumers had health coverage and received care from an out-of-network provider, their health plan usually would not cover the entire out-of-network cost, leaving many with higher, unexpected bills. This is especially common in emergency situations, where consumers may not be able to choose the provider. Even if a consumer goes to an in-network hospital, they may receive care from out-of-network providers at that facility.

In many cases, the out-of-network provider uses balance billing, invoicing consumers for the difference between the charges the provider billed, and the amount paid by the consumer's health plan.

If you receive a surprise billing, contact your insurer and the Department of Insurance (DOI) at 800-595-6053.

Examples of how the new protections apply can be found on the DOI website at https://insurance.ky.gov/ppc/Documents/nsa%20-%20consumer%20bulletin%2012-2021.pdf. Kentuckians can call the No Surprises Act help desk at 800-985-3059 or visit the federal website at https://www.cms.gov/nosurprises for helpful resources.

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