

No Surprises-Good Faith Estimate Policy-Patient Notice
Your Rights and Protections Against Surprise Medical Bills

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 facility, 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 stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services, except as otherwise provided by state law as discussed in the attached New York state law provisions.

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, or intensivist services. These providers **cannot** 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 **cannot** balance bill you, unless you give written consent and give up your protections, except as otherwise provided by state law as discussed in the attached New York state law provisions.

Please see attached for additional protections as part of the New York state law provisions.

You are 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 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 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.

If you think you have been wrongly billed and you have "fully insured coverage" subject to New York law you may contact the New York State Department of Financial Services at 1-800-342-3736 or surprisemedicalbills@dfs.ny.gov. Visit <http://www.dfs.ny.gov> for information about your rights under New York law.

Contact CMS at 1-800-985-3059 for self-funded coverage or coverage bought outside New York. Visit www.hhs.gov for more information about your rights under federal law.

New York State Law Provisions:

Additional Protections for Individuals with “Fully Insured Coverage”

In addition to the federal protections, if your insurance ID card says “fully insured coverage” you are entitled to the following additional protections in New York:

- **Emergency Services:** When receiving emergency services in New York, you **are unable to give** written consent and give up your protections not to be balance billed for post-stabilization services.
- **Certain Services at an In-Network Facility:** When receiving services from an out-of-network provider at an in-network facility, you **cannot** give up your protections for services provided by an out-of-network provider if they are a surprise bill. In this context, a surprise bill is when you’re at an in-network facility and a participating provider was not available, so a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided. In these cases, the out-of-network provider can only bill you your plan’s in-network cost-sharing amount.
- **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) for the full balance billing protection to apply.