Your Rights and Protections Against Surprise Medical Bills

Beginning January 1, ***2022,*** Federal Law protects you^ from "surprise billing" and "balance billing."

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

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 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 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 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 co-payment, 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 get written consent and give up your protections not to be balance 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 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 can't 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 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 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 co-payments, co-insurance, 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've been wrongly billed, call the federal phone number for information and complaints at 1-800-985-3059.

Visit the website https://www.cms.gov/nosurprises/consumers for more information about your rights under the federal law.

^This law does not apply to beneficiaries or enrollees in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills. The protections also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree-only plans; or account-based group health plans.

Surprise Billing - Know Your Rights

Beginning January 1, 2020, Colorado State Law protects you* from "Surprise Billing," also known as "Balance Billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado*.

What is surprise/balance billing, and when does it happen?

If you are seen by a provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network facilities or agencies often bill you the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you cannot be balance-billed:

Emergency services

If you are receiving emergency services, the most you can be billed is your plan's in-network cost-sharing amounts, which are co-payments, deductibles, and/or co-insurance. You cannot be billed for any other amount. This includes both the facility where you receive emergency services and any providers that see you for emergency services.

Please note that not every service provided in an emergency department is an emergency service.

Non-Emergency services at an in-network facility by an out-of-network provider

The facility or agency must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by an out-of-network provider.

You have the right

To request that in-network providers perform all covered medical services.

However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount which are co-payments, deductibles, and/or co-insurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within 60 days of being notified.
- No one, including a provider, hospital, or insurer, can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in any other situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you think you have received a bill for amounts other than your co-payments, deductible, and/or co-insurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does not apply to all Colorado health plans. It only applies if:

- You have a "CO-DOI" on your health insurance ID card, and
- You are receiving care or services provided at a regulated facility in the state of Colorado.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

BCH SUPPLEMENT TO OUT-OF-NETWORK DISCLOSURES

Boulder Community Health (BCH) is a participating provider in many health plans and networks. BCH will provide you with a list of plans in which we participate upon request. Some health plans may use smaller networks for certain products and services they offer, so it is important to check whether BCH participates in the specific plan you are covered by.

BCH would like you to understand that the physician services you receive at our facility are not included in hospital charges. Physicians who provide services at BCH may be independent physicians or they may be employed by BCH. Independent physicians bill separately for the services they provide a nd may or may not participate in the same health plans as BCH. You should check with the physician arranging your hospital services to determine which plans he or she may participate in.

Physicians employed by BCH, including those listed below, participate in the same plans and networks that BCH participates.

- Hospitalists
- Intensivists
- Cardiologists at Boulder Heart

- Neurologists at Associated Neurology
- General Surgeons at Boulder Valley Surgical Associates
- Primary Care Physicians at all BCH Ambulatory Clinics
- Infectious Disease Physicians at Beacon Clinic

To the best of our knowledge, hospital-based physicians, those physician groups that BCH contracts with to provide services within the BCH facility, participate in the same plans and networks that BCH participates. Hospital-based physicians include the following:

- Emergency Medicine Physicians
- Anesthesiologists
- Radiologists
- Pathologists

You should refer to your individual policy or summary of benefits for more information about your out-of-network benefits and coverage and costs for in-network services.

If you have questions about whether BCH is in-network with your insurance, please contact Financial Counseling at 303-415-8115.

If you have questions about whether your provider is in-network with your insurance, please contact your provider's office directly.

Printed Name of Patient or Responsible Party

Relation to Patient

Signature of Patient or Responsible Party