SunState
MEDICAL SPECIALISTS
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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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 copayments, coinsurance 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 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.

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 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.

Florida Law Also Protects You from Balance Billing

Florida law provides additional protections for patients who receive emergency services. If you receive emergency services in Florida, out-of-network physicians and facilities generally cannot bill you more than you in-network cost-sharing amount (such as copayments, coinsurance, deductibles). This means you should not receive a balance bill for emergency services beyond what your health plan requires you to pay for in-network care. Instead, the out-of-network provider and your health plan must work directly with each other to determine the payment amount.

These protections apply to many state-regulated health plans, including most fully insured commercial plans and Health Maintenance Organizations (HMOs) regulated by the State of Florida. Federal law may apply instead for certain plans, including self-funded employer health plans.

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 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 believe you have been improperly balance billed, you may contact:
Florida Department of Financial Services – Consumer Helpline
Phone: 1-877-693-5236
Website: https://www.myfloridacfo.com/division/consumers

Additional information about Florida insurance protections is available from the **Florida Office of Insurance Regulation** at:
https://www.floir.com

For questions or complaints regarding your federal rights under the No Surprises Act, you may also contact:
U.S. Department of Health and Human Services – No Surprises Help Desk
Phone: 1-800-985-3059
Website: www.cms.gov/nosurprises