No Surprises Act (NSA)
(Effective 01/01/2023)

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 is not in your health plan's network.

"Out-of-network" means providers and facilities that have not 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, if your insurance plans to add a cap to what they will accept from an out-of-network provider.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot 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 facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you have 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 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.

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You are 'never required' to give up your protections from balance billing in emergency services and in-network services. You also are 'not required' to get out-of-network care. You can choose a provider or facility in your plan's network at any time, especially if you do not agree with your provider's billing.

When balance billing is not allowed for in-network, you also have these protections:
You are 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/might 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 cannot work out an agreement with your provider, you may contact federal # *1-800-985-3059* for HHS (Health and Human Services). If you feel the need to dispute your bill with HHS, HHS may charge you a fee of $25 for the dispute process. HHS is only accepting/managing disputes for bills that are in excess/extra of $400+ than the Good Faith Estimate that was expected.

www.cms.gov/nosurprises/consumers is a website describing federal protections, laws, and information about your rights.

In summary:
If In-Network & Provider is Contracted & using Insurance > NSA & GFE not needed
If In-Network & Provider is Contracted but Client does not want to use Insurance & chooses to Pay Out of Pocket > NSA & GFE needed
If Out-of-Network & Provider is not Contracted > NSA & GFE needed
If Uninsured & Self-Pay Out of Pocket > NSA & GFE needed