SCA

Surgical Care Affiliates

Your Rights and Protections Against Surprise Medical Bills

For services provided on or after January 1, 2022

When you receive emergency care or are 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, like 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 is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. 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 the 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.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and receive emergency services at a hospital emergency department or freestanding emergency department, the most an out-of-network provider or facility may bill you for such emergency services 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 waive your protections against balance billing for these post-stabilization services.

In addition to the protections under the federal No Surprises Act, the state in which you receive services may have protections that apply to your visit. Under NY law, if your NY insurance card says "fully insured coverage" you can't give written consent and waive protections against balance billing for post-stabilization services. Pennsylvania limit the amount an out-of-network provider and facility can bill you for emergency services to your in-network cost sharing amount. OR limits the amount an out-of-network provider can bill you for emergency services to your in-network cost sharing amount.

Certain services at an in-network hospital or ambulatory surgical center

Should you receive emergency medicine, anesthesia, pathology, radiology, laboratory, assistant surgeon, or hospitalist services by Summit Health out of network providers while you are at an in-network hospital or ambulatory surgical center, the most you would be billed is your plan's in-network cost-sharing amount. 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 waive protections against 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.

Please note that under Pennsylvania law if you receive non-emergent services from an out-of network provider or facility, you may be balance billed or you may be responsible for the entire bill. However, you may still be protected under Federal balance billing prohibitions.

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:
  - o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - o Cover emergency services by out-of-network providers
  - o 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.
  - o Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Pennsylvania Insurance Department at 877-881-6388.

You may also file a grievance with your insurance company. If you are unable to resolve your dispute with the insurance company or if you are not satisfied with how they respond, you may file a complaint with the Pennsylvania Insurance Department by visiting this website: https://www.insurance.pa.gov/Consumers/insurance-complaint/Pages/default.aspx.

Visit https://www.cms.gov/nosurprises for more information about your rights under Federal law.
Visit https://www.insurance.pa.gov/Coverage/health-insurance/no-surprisesact/Pages/FAQs.aspx for more information about your rights under Pennsylvania law.