



OMB Control Number: 0938-1401

Surprise Billing Protection Notification

This document describes your protections against unexpected medical bills. It also asks if you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You may be given a form to sign if you are requesting out-of-network care. You are not required to sign this form and should not sign it if you did not have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you would like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You will receive a form if this provider or facility is not in your health plan's network and is considered out-of-network. This means the provider or facility does not have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.** You will be given a cost estimate for this care.

If your plan covers the item or service you are getting, federal law protects you from higher bills when:

- You are getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you are not sure if these protections apply to you.

If you choose to sign the form, be aware that you may pay more because:

- You are giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

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 balance billed for these post-stabilization services.

Mississippi law generally prohibits balance billing. Under MS Code 83-9-5 (1)(i), if an out-of-network healthcare provider accepts a patient's insurance assignment, then the insurance company will pay the provider directly for the patient's treatment. That payment is considered payment in full to the healthcare provider – this means the provider cannot bill the patient later for any amount more than the payment received from the insurance company, other than normal deductibles or co-pays. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.

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.

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.

Mississippi law generally prohibits balance billing. Under MS Code 83-9-5 (1)(i), if an out-of-network healthcare provider accepts a patient's insurance assignment, then the insurance company will pay the provider directly for the patient's treatment. That payment is considered payment in full to the healthcare provider – this means the provider cannot bill the patient later for any amount more than the payment received from the insurance company, other than normal deductibles or co-pays. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.

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've been wrongly billed, call 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.