No Surprises Act

Beginning January 1, 2022, the No Surprises Act protects certain patients from surprise bills for emergency services at nonparticipating facilities, services provided by nonparticipating providers at participating facilities, and air ambulance services from nonparticipating providers. The No Surprises Act also gives uninsured or self-pay patients the right to receive a good faith estimate of the cost of scheduled care ahead of time.

Your Rights and Protections Against Surprise Medical Bills

Patients are protected from balance billing if they are enrolled in a group health plan, group or individual health insurance coverage, or a Federal Employees Health Benefits Plan for all emergency services. In these cases, patients shouldn't be charged more than their plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When patients see a doctor or other health care provider, they may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. They 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 their 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."

"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.

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 prior authorization for the services.
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility 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, you may:

- File a complaint with the Montana Commissioner of Securities and Insurance at www.csimt.gov/insurance/complaints or by calling 1-800-332-6148.
- File a complaint with the federal government at www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Good Faith Estimate Disclosure

Under the law, health care providers must give patients who don't have certain types of health care coverage or are not using certain types of health care coverage an estimate of the bill for all services related costs prior to services being rendered.

- Patients have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care service at least 3 business your health care facility must provide you with a Good Faith Estimate within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, your health care facility must provide you with a Good Faith Estimate within 3 business days after scheduling. You can also ask your health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, the facility is required to provide a Good Faith Estimate within 3 business days of the request.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.