Your rights and protections against surprise medical bills

You are protected from surprise billing or balance billing when:

- You get emergency care from an out-of-network provider or facility.
- You get treatment from an out-of-network provider at an in-network facility.

What is balance billing or surprise billing?

When you see a health care provider, you may owe certain out-of-pocket costs, such as 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 isn't in your health plan's network.

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

Balance billing is when an out-of-network provider bills you for the difference between the amount they charge and the amount your insurance pays them. This amount is likely more than in-network costs for the same service and may not count toward your annual out-of-pocket limit.

Surprise billing is a balance bill that you did not expect. This can happen when you can't control who cares for you like when you have an emergency or when you visit an in-network facility, but an out-of-network provider treats you.

You are protected from balance billing for:

Emergency services

If you get emergency services from an out-of-network provider or facility, they can only charge you the normal in-network costs, such as copayments and coinsurance. They can't balance bill you for emergency services. This includes services you may get after you are stable. You can consent in writing to allow balance billing for the services you get after you are stable.

Certain services at in-network facilities

An in-network facility may have some out-of-network providers. The most these providers may bill you is for your plan's in-network charges for these services. For example, out-of-network providers may include: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist. These providers can't balance bill you or ask you to allow them to. If you get other types of services at these in-network facilities, out-of-network providers can only balance bill you if you consent in writing to allow them to.

- You are NEVER required to give up your protections from balance billing.
- You are NEVER required to get care out-of-network.
- You CAN choose a provider or facility in your plan's network.

When balance billing isn't allowed, 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 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 your cost-sharing responsibility on what it would pay an in-network provider or facility in your area 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 balance billed, you may contact:

- Samaritan Health Services Customer Service, 541-768-4392 or 800-640-5339.
- U.S. Department of Health and Human Services, 800-985-3059.
- Oregon Department of Consumer and Business Services, 888-877-4894.

Samaritan Health Services

samhealth.org

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