GRATIA
COUNSELING & CONSULTING

No Surprises Act – Legal Notice – MN

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, 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 haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

Protections against balance billing

Laws are in place to protect you from being billed more for out-of-network services than your in-network cost sharing amount (copay, coinsurance, or deductible). For example, in Minnesota, Minn. Stat. 62K.11 protects patients against balance billing in some circumstances. (see https://www.revisor.mn.gov/statutes/cite/62K.11). (See also Minnesota Statutes 62Q.556 – Unauthorized Provider Services.)

Emergency care from an out-of-network provider or facility

The most you can be billed for emergency services is your plan's in-network cost sharing amount. This includes services you may get after you are in stable condition, unless you sign a written consent allowing us to balance bill you for those services.

In-network hospitals, surgery centers, and facilities

You can only be billed your plan's in-network cost sharing amount if you:

- Saw an out-of-network physician.
- Received out-of-network services for anesthesia, pathology, radiology, laboratory, or emergency care.
- Did not know that the provider you saw was out of your network or an in-network provider was not available.
- Did not anticipate needing the services you received.

- An in-network provider has taken a specimen from you for testing and sent it to an out-of-network testing facility without your written consent.

For services listed above, your out-of-network provider must have your written consent to balance bill you. Signing the consent gives up your protection not to be balanced billed. The provider cannot ask you to give up this protection.

Other protections

When balance billing is not allowed, you are only responsible for paying your share of the costs (such as copayments, coinsurance, or the deductible that you would pay if the provider or facility was in-network.)

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base your cost sharing for emergency services on what it would pay an in-network provider or facility. This amount must be shown in your Explanation of Benefits.
- Count any amount you pay for emergency services on what it would pay an out-of-network services toward your deductible and out-of-pocket limit.

  You are not required to get care out-of-network; you can choose a provider or facility in your plan's network.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

For more information

If you believe you have been wrongly billed, you may contact 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.
Visit www.ag.state.mn.us/consumer/health/default.asp for more information about your rights under Minnesota law.

Uninsured and Self-Pay Patients

Your right to a Good Faith Estimate

Your rights under the law

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You have the right to a written estimate of your medical bill (called a Good Faith Estimate) when:

- Your appointment is scheduled 3 or more days in advance and
- You will not be using insurance to pay for the visit or, you do not have insurance.

You may also request an estimate if one is not automatically provided.

The Good Faith Estimate will include the expected charges of the item or service, such as: the cost of the non-emergent clinic visit, plus any tests, procedures, and supplies.

As a service to you, we provide a fee schedule for all of our patients to view so they know the Good Faith Estimate for all services.

Make sure to save a copy or photo of your Good Faith Estimate. If you receive a bill from us that is at least $400 more than your estimate, you can dispute it. This must be done within 120 calendar days of receiving the bill.

If you have questions

Our patient account representatives can answer questions about your Good Faith Estimate and explain the possible costs of your care.

Company Phone - 763-333-1553

For more information about your rights and the No Surprise Bill Act, visit:
www.cms.gov/nosurprises