Your Rights and Protections Against Surprise Medical Bills

When you get emergency care, you are protected from surprise billing or balance billing

Like visiting an in-network facility, St. Michael's Elite Hospital will only charge you the amount your insurance plan requires as coinsurance, copayments, and deductibles. This amount is based on the terms of your health insurance plan.

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**."

"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 are 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 the provider or facility may bill you 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 give up your protections not to be balanced billed for these post-stabilization services.

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 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 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 deductible and out-of-pocket limit.

What is an Explanation of Benefits?

You may receive an Explanation of Benefits (EOB) from your insurance company shortly after your visit. **An EOB is NOT a bill**. Do not be concerned. You do not owe us anything at this time.

The health care provider and your health plan are responsible for negotiating the total payment amount from the plan to the provider through an independent dispute resolution process. An EOB is simply a communication tool from your insurance company informing you that the claim process how begun. If you have questions during the claim process, please don't hesitate to call a friendly advocate at (281) 980-4357.

For more information:

If you believe you've been wrongly billed, you may contact:

Texas Department of Insurance
333 Guadalupe
Austin, TX 78701
1-800-252-3439

Or call the No Surprises Help Desk at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit https://www.tdi.texas.gov/tips/texas-protects-consumers-from-surprise-medical-bills.html for more information about your rights under Texas state laws.