Putting The Pieces Together:

Your Guide to Surprise Medical Bills

ISSUE FOUR | PART A

To health!

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Understanding a Surprise Medical Bill at a Glance

You have health insurance and you went to a healthcare provider for services – now you have a bill. Sometimes you're responsible for the bill in its entirety. But sometimes you may not understand why you have received a bill – this is often referred to as "surprise medical billing." In New Jersey, you may have special protections under the law if the law applies to your health insurance policy.

What Is A Surprise Medical Bill

- A bill for healthcare services or procedures that you received from an out-of-network healthcare provider without knowing that provider was not in network with your insurance plan.
- One way this can happen is when you go to an in-network hospital for a healthcare procedure but one of the doctors who treats you is out of network.

Avoiding Surprise Medical Bills

- Review your health insurance policy documents and familiarize yourself with the benefit design.
- Your benefit design refers to all of the features of your specific health insurance policy.

Healthcare Provider Assistance

- Healthcare providers will give you as much information as possible about their network status.
- If you decide you want to use a specific healthcare provider that is out of network, it is very important to double check with your insurance company that you have an out-of-network benefit. If you don't have an out-of-network benefit you can still choose to use the doctor but you will be responsible for the entire bill.

Other Resources

- Healthcare provider websites are a useful source of information.
- Your health insurance company is always the best resource for specific information about your policy. Besides you, the health insurance company is the only other source that has a copy of your specific policy.

Your Guide to Surprise Medical Bills

In the normal course of receiving healthcare, it is possible to receive a bill that ***is entirely your responsibility*** **(see NJHA's guide to medical billing** *http://www.njha.com/media/525149/PTPT-Understanding-Our-Medical-Bills.pdf*.

But sometimes people receive bills and don't understand why – this has often been referred to as a "surprise medical bill." In New Jersey, there are some special protections against these types of bills. You must check with your health insurance company to make sure the protections apply to your health insurance policy. Not all health insurance companies have to follow the state's rules; some are subject to special protections in federal law.

1. What Is A Surprise Medical Bill

A surprise medical bill happens when you unknowingly use a healthcare provider who is not in your health insurance company's network, or "in network".

An example of how this might happen is when you have an emergency and go to the hospital. The hospital is in network, but not all of the healthcare providers in the hospital are in the same health insurance company networks. This is because not all of the healthcare providers in a hospital are employed by the hospital. Some of them contract to use the hospital to see patients. Some don't even have contracts, they simply have been reviewed and granted privileges.

In an emergency, you most likely are unable to choose the doctors, specialists or surgeons who treat you. But if you have an insurance policy subject to New Jersey protections you will never be "balance billed" in an emergency by any healthcare provider that provides emergency treatment.

Balance Bill

A balance bill is the charges the patient is asked to pay beyond what their insurance company covered for an out-of-network service, provider or facility.

New Jersey law also protects you in non-emergency instances if you didn't know an out-of-network provider was treating you – if the law applies to your health insurance policy.

2. How to Avoid A Surprise Medical Bill

One of the key ways to prevent a surprise medical bill is to familiarize yourself with your health insurance policy's benefit design.

Benefit Design

The term benefit design refers to all of the features of your health insurance policy including things such as the services that are covered and the cost-sharing obligations of a plan. Benefit design is part of how your monthly premium payment is determined.

Prior to having any scheduled healthcare treatments, services or supplies, double check with your health insurance company to make sure the treatment is a covered benefit and doesn't have any special authorization requirements.

3.

Healthcare Provider Assistance

Healthcare providers will make sure to share as much information as possible so that you can make an informed decision about the provider you choose to use. That is why a healthcare provider will let you know prior to performing a non-emergency, scheduled service or procedure:

- The healthcare provider's network status.
- How to inquire about the network status of other healthcare providers that may treat you.
- That you should contact your health insurance company for the most accurate information about your health insurance policy.
- That you have in-network payment protections **unless you choose** to use an out-of-network healthcare provider.
- That you have the right to report inappropriate balance bills.

Healthcare providers will also make sure that even if your health insurance policy isn't protected by the law that you may:

- Receive some of the healthcare services from an out-of-network provider
- You may have a financial responsibility greater than your in-network cost-sharing amounts.
- You should contact your insurance company for more information.

By letting you know this, healthcare providers hope you will be able to understand you are choosing to go out of network or you can check with your insurance company first and then schedule your service or procedure.

WHAT IF I WANT TO USE A FACILITY OR PROVIDER I KNOW IS OUT-OF-NETWORK?

If you have a health insurance policy with an out-of-network benefit, you can choose to go to an out-of-network provider. It is very important you double check with your health insurance company whether you have this benefit – many policies do not.

An out-of-network healthcare provider will advise you that they are outside of your network, that you will be responsible for additional costs and that you should check with your health insurance company to find out what those costs could be.

Out-of-Network Benefit

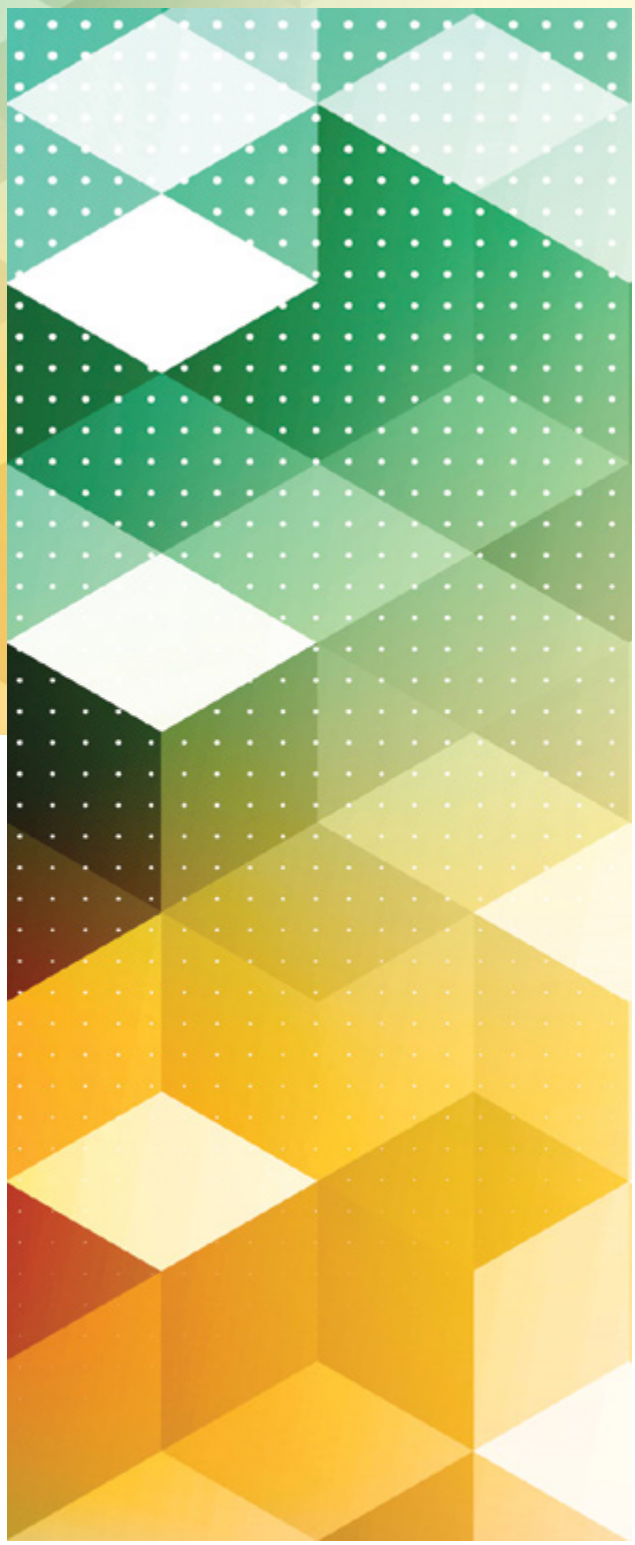
An out-of-network benefit means your health insurance will still cover an allowed amount of the cost of your care, but you could still be responsible for copayment, deductible, coinsurance and/or the remaining balance of the cost of your care. Most often, an out-of-network benefit covers less than an in-network benefit, and if your plan does not have an out-of-network benefit, you will be responsible for the entire bill.

4.

Other Resources

Healthcare providers' websites are also a great resource for information. They list the insurance that they accept and sometimes costs as well as patient billing information.

Finally, your most valuable resource will always be your health insurance company. They have all of the specific information and requirements for your individual coverage. The number for your health insurance company can always be found on your health insurance card.



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If you have other questions or concerns, call the customer service phone number on your insurance card.

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