# Your Notice of Rights and Protections Against Surprise Medical Bills

**For patients with medical plan coverage:** When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

**For patients without medical plan coverage (uninsured/self-pay patients):**
You have the right to request and receive a good faith estimate of expected charges upon or prior to scheduling an item or service with the provider of service.

*NOTE: The below summary of rights and protections apply to out-of-network limitations for insured patients and are not applicable to self-pay/uninsured patients.*

## 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.

## 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 cannot 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.

Ohio law protects you from receiving surprise medical bills for emergency services of patients for services otherwise covered by your plan if provided by in-network providers. The law mirrors the above federal law and does not allow the practice of balance billing in this

instance, leaving any price negotiation to be handled between the health provider and the health plan.

***Certain Services at an In-Network Hospital or Ambulatory Surgical Center***

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

**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.**

Ohio law protects you from receiving surprise medical bills, in certain circumstances, for unexpected out-of-network care for services otherwise covered by your plan if provided by in-network providers. The law does not allow the practice of balance billing in these instances, leaving any price negotiation to be handled between the health provider and the health plan.

## When balance billing isn't allowed, 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 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 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.

## Resolutions:

If you believe you've been wrongly billed, you may call Genesis HealthCare System Patient Resource Center at 740-454-4335. Although most concerns can be resolved by the Genesis Patient Resource Center Team, if you feel you need more help or feel your needs would be better addressed by an outside agency, you may contact: The Ohio Department of Insurance, at 1-800-686-1578, 50 W Town Street Suite 300, Columbus Ohio 43215; or CMS at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059.

Visit *https://www.cms.gov/nosurprises* or *https://insurance.ohio.gov/wps/portal/gov/odi/consumers/health/surprise-billing* for more information about your rights under federal or Ohio law.